2012
CUMULATIVE
POCKET SUPPLEMENT

IDAHO CODE

Compiled Under the Supervision of the
Idaho Code Commission

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TITLE 41

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ISBN 978-0-672-83888-0 (Set)
ISBN 978-1-4224-6374-1

(Pub.42205)

PUBLISHER'S NOTE

Amendments to laws and new laws enacted since the publication of the bound volume down to and including the 2012 regular session are compiled in this supplement and will be found under their appropriate section numbers.

This publication contains annotations taken from decisions of the Idaho Supreme Court and the Court of Appeals and the appropriate federal courts. These cases will be printed in the following reports:

Idaho Reports
Pacific Reporter, 3rd Series
Federal Supplement, 2nd Series
Federal Reporter, 3rd Series
United States Supreme Court Reports, Lawyers' Edition, 2nd Series

Title and chapter analyses, in these supplements, carry only laws that have been amended or new laws. Old sections that have nothing but annotations are not included in the analyses.

Following is an explanation of the abbreviations of the Court Rules used throughout the Idaho Code.

I.R.C.P.	Idaho Rules of Civil Procedure
I.R.E.	Idaho Rules of Evidence
I.C.R.	Idaho Criminal Rules
M.C.R.	Misdemeanor Criminal Rules
I.I.R.	Idaho Infraction Rules
I.J.R.	Idaho Juvenile Rules
I.C.A.R.	Idaho Court Administrative Rules
I.A.R.	Idaho Appellate Rules

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USER'S GUIDE

To assist the legal profession and the layperson in obtaining the maximum benefit from the Idaho Code, a User's Guide has been included in the first, bound volume of this set.

ADJOURNMENT DATES OF SESSIONS OF LEGISLATURE

Year	Adjournment Date
2011	April 7, 2011
2012	March 29, 2012

TITLE 41

INSURANCE

CHAPTER 2

THE DEPARTMENT OF INSURANCE

41-212. Orders, notices. — (1) Orders and notices of the director shall be effective only when in writing signed by him or by his authority.

(2) Every such order shall state its effective date, and shall concisely state:

(a) Its intent or purpose.

(b) The grounds on which based.

(c) The provisions of this code pursuant to which action is taken or proposed to be taken; but failure to so designate a particular provision shall not deprive the director of the right to rely thereon.

(3) Except as may be provided in this code respecting particular procedures, an order or notice may be given by:

(a) Personal service upon the person to be ordered or notified;

(b) Mailing it, postage prepaid, by regular United States mail, or by certified mail, return receipt requested, addressed to the person at his residence or principal place of business as last of record in the department; or

(c) Where a party has appeared in a contested case or has not yet appeared but has consented or agreed in writing to service by facsimile transmission (FAX) or e-mail as an alternative to personal service or service by mail, such orders or notices may be served by FAX or by e-mail in lieu of service by mail or personal service.

(4) Service of orders and notices is complete when a copy is personally served upon the person to be served, or when a copy properly addressed and postage prepaid is deposited in the United States mail or the statehouse

mail, if the person is a state employee or state agency, or when there is an electronic verification that a FAX or an e-mail has been sent.

History.
1961, ch. 330, § 29, p. 645; am. 2012, ch. 157, § 1, p. 433.

STATUTORY NOTES

Amendments.
The 2012 amendment, by ch. 157, in subsection (3), divided the existing provisions into an introductory paragraph and present paragraphs (a) and (b), deleted "delivery to" at the end of the introductory paragraph, added "Personal service upon" in paragraph (a), substituted the present provisions in paragraph (b) for "mailing it, postage prepaid, addressed to him at his residence or principal place of business as last of record in the department. Notice so mailed shall be deemed to have been given when deposited in a letter depository of a United States post office", and added paragraph (c); and added subsection (4).

Compiler's Notes.
The abbreviation in parentheses so appeared in the law as enacted.

CHAPTER 4
FEES AND TAXES

SECTION.

41-406. Deposit and report of fees, licenses and taxes. — (1) The director shall transmit all taxes, fines and penalties collected by him to the state treasurer as provided under section 59-1014, Idaho Code. The director shall file with the state controller a statement of each deposit thus made. All such funds received shall be deposited into the department of insurance suspense account.

Such funds shall be distributed as follows:

(a) The director may deposit up to twenty percent (20%) of the funds received in the insurance refund account which is hereby created for the purpose of repaying overpayments of any taxes, fines, and penalties or other erroneous receipts. There is hereby appropriated out of the insurance refund account so much thereof as shall be necessary for the payment of refunds. Any unencumbered balance remaining in the insurance refund account on June 30 of each and every year in excess of forty thousand dollars ($40,000) shall be transferred to the general fund and the state controller is hereby authorized and directed on such dates to make such transfers unless the board of examiners, which is hereby authorized to do so, changes the date of transfer or sum to be transferred.

(b) That portion of the premium tax, payable to the public employee retirement fund as provided in section 59-1394, Idaho Code, shall be distributed to that fund.

(c) That portion of the premium tax necessary to cover administrative costs incurred by the department in placing insurance companies or any other insurance entities into receivership or under administrative supervision, and such costs cannot be satisfied from the assets of these

companies or entities, shall be distributed to the insurance insolvency administrative fund which is hereby created. There is hereby appropriated out of the insurance insolvency administrative fund so much thereof as shall be necessary, but not to exceed two hundred thousand dollars ($200,000) in any one (1) fiscal year, for the payment of the department's administrative expenses incurred in carrying out such receiverships or supervision. A balance of one hundred thousand dollars ($100,000) shall be maintained in this fund on June 30 of each year.

(d) After all other deductions authorized in this section have been made, if the premium tax remaining exceeds forty-five million dollars ($45,000,000), one-fourth (1/4) of such excess is hereby appropriated and shall be paid to the Idaho high risk individual reinsurance pool established in chapter 55, title 41, Idaho Code, and one-fourth (1/4) of such excess above fifty-five million dollars ($55,000,000) is hereby appropriated and shall be paid to the Idaho health insurance access card fund, established in section 56-242, Idaho Code, with eighty percent (80%) of such moneys to be appropriated to the CHIP Plan B subaccount and the children's access card program subaccount and twenty percent (20%) of such moneys, not to exceed one million two hundred thousand dollars ($1,200,000) per year, to be appropriated to the small business health insurance pilot program subaccount.

(e) The balance of the premium tax, fines and penalties shall be distributed to the general fund of the state of Idaho.

(f) All moneys received for fees, licenses and miscellaneous charges collected shall be distributed to the insurance administrative account.

(2) The director shall make and file with the state controller an itemized statement of the fees, licenses, taxes, fines and penalties collected by him during the preceding month.

History.

I.C., § 41-406, as added by 1984, ch. 23, § 3, p. 38; am. 1987, ch. 340, § 5, p. 720; am. 1993, ch. 118, § 1, p. 295; am. 1994, ch. 180, § 82, p. 420; am. 2000, ch. 64, § 1, p. 144; am. 2000, ch. 472, § 18, p. 1602; am. 2003, ch. 308, § 8, p. 844; am. 2012, ch. 158, § 1, p. 433.

STATUTORY NOTES

Amendments.

The 2012 amendment, by ch. 158, deleted "and shall deliver a certified copy of the statement to the state treasurer" from the end of subsection (2).

CHAPTER 9

INSURANCE ADMINISTRATORS

41-911. Home state license. — (1) A person shall apply to be an administrator in its home state and shall receive a license from the regulatory authority of its home state prior to performing any function of an administrator in this state.

(2) A person applying to Idaho as the home state shall submit to the director an application in the form prescribed by the director that shall include or be accompanied by the following information and documents:

(a) All basic organizational documents of the applicant, including any articles of incorporation, articles of association, partnership agreement, trade name certificate, trust agreement, shareholder agreement, certificate of existence from the Idaho secretary of state and other applicable documents and all amendments to such documents;

(b) The bylaws, rules, regulations or similar documents regulating the internal affairs of the applicant;

(c) NAIC biographical affidavits for the individuals who are directly or indirectly responsible for the conduct of affairs of the applicant, including all members of the board of directors, board of trustees, executive committee or other governing board or committee, the principal officers in the case of a corporation or the partners or members in the case of a partnership, association or limited liability company, any shareholders or members holding directly or indirectly ten percent (10%) or more of the voting stock, voting securities or voting interest of the applicant and any other person who directly or indirectly exercises control or influence over the affairs of the applicant;

(d) Audited annual financial statements or reports for the two (2) most recent fiscal years that demonstrate that the applicant has a positive net worth. If the applicant has been in existence for less than two (2) fiscal years, the uniform application shall include financial statements or reports, certified by at least two (2) officers, owners or directors of the applicant and prepared in accordance with GAAP, for any completed fiscal years and for any month during the current fiscal year for which such financial statements or reports have been completed. An audited annual financial report prepared on a consolidated basis shall include a columnar consolidating or combining worksheet that shall be filed with the report and include the following:

(i) Amounts shown on the consolidated audited financial report shall be shown on the worksheet;

(ii) Amounts for each entity shall be stated separately; and

(iii) Explanations of consolidating and eliminating entries shall be included.

The applicant shall also include such other information as the director may require in order to review the current financial condition of the applicant;

(e) In lieu of submitting audited financial statements, and upon written application by an applicant and good cause shown, the director may grant a hardship exemption from filing audited financial statements and allow the submission of unaudited financial statements. Acceptable formats for unaudited financial statements, which shall include notes, are:

(i) Reports compiled or reviewed by a certified public accountant; or

(ii) Internal financial reports prepared in accordance with GAAP, certified by at least two (2) officers, owners or directors of the administrator.

If unaudited financial statements are submitted, the applicant must also secure and maintain a surety bond in a form prescribed by the director for the use and benefit of the director to be held in trust for the benefit and protection of covered persons and any insurer or self-funded plan against loss by reason of acts of fraud or dishonesty, for the greater of ten percent (10%) of funds handled for the benefit of Idaho residents or twenty thousand dollars ($20,000). Administrators of self-funded plans in Idaho are subject to the mandatory surety bond requirement found in subsection (8) of this section, regardless of whether they file audited or unaudited financial reports;

(f) A statement describing the business plan, including information on staffing levels and activities, proposed in this state and nationwide. The plan shall provide details setting forth the applicant's capability for providing a sufficient number of experienced and qualified personnel in the areas of claims processing, recordkeeping and underwriting;

(g) The license application fee as provided for by rule; and

(h) Such other pertinent information as may be required by the director.

(3) An administrator licensed or applying for licensure under the provisions of this section shall make available for inspection by the director, copies of all contracts with insurers or other persons utilizing the services of the administrator.

(4) An administrator licensed or applying for licensure under the provisions of this section shall produce its accounts, records and files for examination, and make its officers available to give information with respect to its affairs, as often as reasonably required by the director.

(5) The director may refuse to issue a license if the director determines that the applicant or any individual responsible for the conduct of affairs of the applicant is not competent, trustworthy, financially responsible or of good personal and business reputation, or has had an insurance or an administrator certificate of authority or license denied or revoked for cause by any jurisdiction, or if the director determines that any of the grounds set forth in section 41-915, Idaho Code, exist with respect to the applicant.

(6) A license issued under this section shall remain valid, unless surrendered, suspended or revoked by the director, for so long as the administrator continues in business in this state and remains in compliance with the provisions of this chapter and any applicable rules.

(7) An administrator licensed or applying for licensure under the provisions of this section shall immediately notify the director of any material change in its ownership, control or other fact or circumstance affecting its qualification for a license in this state.

(8) An administrator licensed or applying for a home state license that administers or will administer self-funded health plans subject to regulation under chapter 40 or 41, title 41, Idaho Code, shall maintain a surety bond in a form prescribed by the director for the use and benefit of the director to be held in trust for the benefit and protection of covered persons and any insurer or self-funded plan against loss by reason of acts of fraud or dishonesty. The bond shall be in the greater of the following amounts:

(a) One hundred thousand dollars ($100,000); or

(b) An amount equal to the greater of ten percent (10%) of the contributions collected by the administrator from self-funded plans subject to regulation under chapters 40 and 41, title 41, Idaho Code, or ten percent (10%) of the benefits paid by such self-funded plans administered during the preceding calendar year. If the administrator did not administer any self-funded plans subject to regulation under chapter 40 or 41, title 41, Idaho Code, during the preceding calendar year, the bond shall be in an amount equal to ten percent (10%) of the contributions projected to be received by the administrator from such self-funded plans during the next calendar year.

History.
I.C., § 41-911, as added by 2010, ch. 31, § 2, p. 51; am. 2012, ch. 156, § 1, p. 430.

STATUTORY NOTES

Amendments.
The 2012 amendment, by ch. 156, in paragraph (2)(d), substituted "demonstrate" for "prove" in the first sentence and "certified by at least two (2) officers, owners or directors" for "certified by an officer" in the second sentence; added paragraph (2)(e), redesignating former paragraphs (2)(e), (f), and (g) as present paragraphs (2)(f), (g), and (h); substituted "applicant" for "administrator" three times in subsection (5); and, in the introductory paragraph in subsection (8), inserted "in a form prescribed by the director" and substituted "any insurer or self-funded plan" for "the insurer or insurers."

41-914. Annual report. — (1) Each administrator licensed under the provisions of this chapter shall file an annual report for the preceding calendar year with the director on or before July 1 of each year, or within such extension of time as the director for good cause may grant. The annual report shall include:

(a) An audited financial statement attested to by an independent certified public accountant. An audited annual financial report prepared on a consolidated basis shall include a columnar consolidating or combining worksheet that shall be filed with the report and include the following:

(i) Amounts shown on the consolidated audited financial report shall be shown on the worksheet;

(ii) Amounts for each entity shall be stated separately; and

(iii) Explanations of consolidating and eliminating entries shall be included.

(b) In lieu of submitting an audited financial statement, and upon written application by an administrator and good cause shown, the director may grant a hardship exemption from filing audited financial statements and allow the submission of unaudited financial statements. Acceptable formats for unaudited financial statements, which shall include notes, are:

(i) Reports compiled or reviewed by a certified public accountant; or

(ii) Internal financial reports prepared in accordance with GAAP, certified by at least two (2) officers, owners or directors of the administrator.

If unaudited financial statements are submitted, the administrator must secure and maintain a surety bond in a form prescribed by the director for

the use and benefit of the director to be held in trust for the benefit and protection of covered persons and any insurer or self-funded plan against loss by reason of acts of fraud or dishonesty, for the greater of ten percent (10%) of funds handled for the benefit of Idaho residents or twenty thousand dollars ($20,000).

(2) The annual report shall be in the form and contain such matters as the director prescribes and shall be verified by at least two (2) officers, owners or directors of the administrator.

(3) The annual report shall include the complete names and addresses of all insurers and for self-funded plans, all employers and trusts, with which the administrator had agreements during the preceding fiscal year. The report shall also include the number of Idaho residents covered by each of the plans.

History.
I.C., § 41-914, as added by 2010, ch. 31, § 2, p. 51; am. 2012, ch. 156, § 2, p. 430.

STATUTORY NOTES

Amendments.
The 2012 amendment, by ch. 156, in subsection (1), divided the existing provisions of the introductory paragraph into the present introductory paragraph and paragraph (a), added the (a) designation, substituting "attested to" for "performed" and redesignating the subordinate paragraphs, and added paragraph (b); in subsection (2), added the designation and inserted "annual" and "owners or directors"; and redesignated former subsection (2) as subsection (3), inserting "and for self-funded plans, all employers and trusts" and adding the last sentence.

CHAPTER 10

PRODUCER LICENSING

SECTION.

41-1003. Definitions. [Effective July 1, 2013.] — (1) "Business entity" means a corporation, association, partnership, limited liability company, limited liability partnership or other legal entity.

(2) "Home state" means the District of Columbia and any state or territory of the United States or any province of Canada in which an insurance producer maintains his or her principal place of residence or principal place of business and is licensed to act as an insurance producer.

(3) "License" means a document issued by the director authorizing a

person to act as an insurance producer for the lines of authority specified in the document. The license itself does not create any authority, actual, apparent or inherent, in the holder to represent or commit an insurance carrier.

(4) "Limited lines insurance" is insurance which restricts the authority of the license to less than the total authority prescribed in the associated major lines pursuant to section 41-1008(1)(a) through (g), Idaho Code, and shall include, but not be limited to: credit life, credit disability, credit property, credit unemployment, involuntary unemployment, mortgage life, mortgage guaranty, mortgage disability, guaranteed automobile protection (GAP) insurance, transportation baggage insurance, transportation ticket policies covering personal accident insurance, pet insurance, portable electronics insurance or any other line of insurance that the director deems necessary to recognize for the purposes of complying with section 41-1009(5), Idaho Code.

(5) "Limited lines producer" means a producer authorized by the director to sell, solicit or negotiate limited lines insurance.

(6) "Negotiate" means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms or conditions of the contract, provided that the person engaged in the act either sells insurance or obtains insurance from insurers for purchasers.

(7) "Person" means an individual or a business entity.

(8) "Producer" means a person required to be licensed under the laws of this state to sell, solicit or negotiate insurance.

(9) "Resident" means a person whose home state is Idaho or any other particular state identified in conjunction with the use of the term.

(10) "Sell" means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurance company.

(11) "Solicit" means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular company or companies.

(12) "Terminate" means the cancellation of the relationship between an insurance producer and the insurer or the termination of a producer's authority to transact insurance for or on behalf of an insurer.

(13) "Uniform application" means the current version of the national association of insurance commissioners (NAIC) uniform application for resident and nonresident producer licensing.

(14) "Uniform business entity application" means the current version of the NAIC uniform business entity application for resident and nonresident business entities.

History.
I.C., § 41-1003, as added by 2001, ch. 296, § 3, p. 1044; am. 2012, ch. 226, § 1, p. 619.

STATUTORY NOTES

Amendments.
The 2012 amendment, by ch. 226, inserted "portable electronic insurance" near the end of subsection (4).

Compiler's Notes.
For this section as effective until July 1, 2013, see the bound volume.

Effective Dates.
Section 16 of S.L. 2012, ch. 206 provided that the act should take effect on and after July 1, 2013.

41-1004. License required. [Effective July 1, 2013.] — (1) A person shall not sell, solicit or negotiate insurance in this state for any class or classes of insurance unless the person is licensed as a producer for that line of authority in accordance with this chapter.

(2) A person shall not, for a fee, engage in the business of offering any advice, counsel, opinion or service with respect to the benefits, advantages or disadvantages under any policy of insurance that could be issued in Idaho unless that person is:

(a) A licensed insurance producer offering advice concerning a class of insurance as to which the producer is licensed to transact business in this state;

(b) An attorney rendering services in the performance of the duties of an attorney;

(c) A certified public accountant rendering services in the performance of the duties of a certified public accountant, as authorized by law;

(d) An actuary rendering actuarial services if such actuary is a member of an organization determined by the director as establishing standards for the actuarial profession;

(e) A person providing services to producers or authorized insurers only;

(f) A person rendering services as an expert pursuant to the Idaho rules of evidence;

(g) An investment adviser, investment adviser representative or federally covered investment adviser as defined in section 30-14-102, Idaho Code; or

(h) A person rendering such services pursuant to a license issued in accordance with sections 41-1081 through 41-1089 of this chapter [, Idaho Code].

History.
I.C., § 41-1004, as added by 2001, ch. 296, § 3, p. 1044; am. 2002, ch. 282, § 1, p. 825; am. 2004, ch. 45, § 6, p. 169; am. 2012, ch. 226, § 2, p. 619.

STATUTORY NOTES

Amendments.
The 2012 amendment, by ch. 226, inserted paragraph (2)(h) and made stylistic changes.

Compiler's Notes.
For this section as effective until July 1, 2013, see the bound volume.

Effective Dates.
Section 16 of S.L. 2012, ch. 206 provided that the act should take effect on and after July 1, 2013.

41-1081. Requirements for sale of portable electronics insurance — Findings — Purpose. [Effective July 1, 2013.] — (1) Sections 41-1081 through 41-1089, Idaho Code, set forth requirements for the sale of portable electronics insurance in this state.

(2) The legislature finds that portable electronics insurers and insurance producers who sell, solicit or negotiate the offer or sale of such insurance in this state shall be supervised and regulated by the department of insurance in a uniform and consistent manner.

History.
I.C., § 41-1081, as added by 2012, ch. 226, § 3, p. 619.

STATUTORY NOTES

Effective Dates.
Section 16 of S.L. 2012, ch. 206 provided that the act should take effect on and after July 1, 2013.

41-1082. Definitions. [Effective July 1, 2013.] — As used in sections 41-1081 through 41-1089, Idaho Code:

(1) "Customer" means a person who purchases portable electronics or services.

(2) "Enrolled Customer" means a customer who purchases coverage under a portable electronics insurance policy issued to a vendor of portable electronics, which vendor would be the insured under a master or group policy.

(3) "Location" means any physical location in the state of Idaho or any website, call center site or similar location directed to residents of the state of Idaho.

(4) "Portable electronics" means electronic devices that are portable in nature and includes accessories and any services related to the use of such device.

(5)(a) "Portable electronics insurance" means insurance providing coverage for the repair or replacement of portable electronics against any one (1) or more of the following causes of loss: loss of the portable electronic device, theft, inoperability due to mechanical failure, malfunction, damage or other similar causes of loss;

(b) "Portable electronics insurance" does not include:

(i) A service contract as defined in section 41-114A, Idaho Code;

(ii) A policy of insurance covering a seller's or a manufacturer's obligations under a warranty; or

(iii) A homeowner's, renter's, private passenger automobile, commercial multi-peril or similar insurance policy.

(6) "Portable electronics transaction" means:

(a) The sale or lease of portable electronics by a vendor to a customer; or

(b) The sale of a service related to the use of portable electronics by a vendor to a customer.

(7) "Supervising entity" means a business entity that is a licensed insurer or insurance producer that is authorized by an insurer to supervise the administration of a portable electronics insurance program.

(8) "Vendor" means a person in the business of engaging in portable electronics transactions directly or indirectly.

History.
I.C., § 41-1082, as added by 2012, ch. 226, § 4, p. 619.

STATUTORY NOTES

Effective Dates.
Section 16 of S.L. 2012, ch. 206 provided that the act should take effect on and after July 1, 2013.

41-1083. Licensure of vendors. [Effective July 1, 2013.] — (1) A vendor is required to hold a limited lines license to sell or offer coverage under a policy of portable electronics insurance.

(2) A limited lines license issued pursuant to the provisions of this section shall authorize any employee or authorized representative of the vendor to sell or offer coverage under a policy of portable electronics insurance to a customer at each location at which the vendor engages in portable electronics transactions.

(3) The supervising entity shall maintain a registry of vendor locations that are authorized to sell or solicit portable electronics insurance coverage in this state. Upon request by the director to the supervising entity, the registry shall be open to inspection and examination by the director during regular business hours of the supervising entity.

(4) Notwithstanding any other provision of law, a limited lines license issued pursuant to this section shall authorize the licensee and its employees or authorized representatives to engage in those activities that are permitted in this section.

History.
I.C., § 41-1083, as added by 2012, ch. 226, § 5, p. 619.

STATUTORY NOTES

Effective Dates.
Section 16 of S.L. 2012, ch. 206 provided that the act should take effect on and after July 1, 2013.

41-1084. Requirements for sale of portable electronics insurance. [Effective July 1, 2013.] — (1) At every location where portable electronics insurance is offered or sold to customers, brochures or other written materials must be provided by the vendor to a prospective customer which:

(a) Disclose that portable electronics insurance may duplicate coverage already provided by a customer's homeowner's insurance policy, renter's insurance policy or other source of insurance coverage;

(b) State that the purchase by the customer of a portable electronics insurance policy is not required in order to purchase or lease portable electronics or related services;

(c) Summarize the material terms of the insurance coverage, including:

(i) The identity of the insurer;

(ii) The identity and contact information of the supervising entity;

(iii) The amount of any applicable deductible and how it is to be paid;

(iv) Benefits of the insurance coverage; and

(v) Key terms and conditions of the insurance coverage such as whether portable electronics may be repaired or replaced with similar make and model, reconditioned or nonoriginal manufacturer parts or equipment;

(d) Set forth the process for filing a claim, including a description of how to return portable electronics and any deadlines applicable thereto, any fees that may apply and the maximum fee applicable in the event the customer fails to comply with any equipment return requirements; and

(e) State that an enrolled customer may cancel enrollment for coverage under a portable electronics insurance policy at any time and that the person who paid the premium shall receive a pro rata refund or credit of any applicable unearned premium.

(2) The director may order a vendor to stop using any brochure or other written material that violates the requirements of this section or is otherwise found to be misleading or false.

(3) Portable electronics insurance may be offered on a month to month or other periodic basis as a group or master commercial inland marine policy issued to a vendor of portable electronics for its enrolled customers.

(4) Eligibility and underwriting standards for customers electing to purchase portable electronics insurance coverage shall be established for each portable electronics insurance program by the insurer issuing a policy to a vendor.

History.
I.C., § 41-1084, as added by 2012, ch. 226, § 6, p. 619.

STATUTORY NOTES

Effective Dates.
Section 16 of S.L. 2012, ch. 206 provided that the act should take effect on and after July 1, 2013.

41-1085. Authority of vendors of portable electronics. [Effective July 1, 2013.] — (1) Notwithstanding any other provision of law, the employees and authorized representatives of vendors may sell or offer portable electronics insurance to customers and shall not be subject to licensure as an insurance producer under the provisions of this chapter provided that:

(a) The vendor obtains a limited lines license to authorize its employees or authorized representatives to sell or offer portable electronics insurance pursuant to the provisions of this section;

(b) The insurer issuing the portable electronics insurance either directly supervises or appoints a supervising entity who shall supervise the administration of the program, to include development of a training program for employees and authorized representatives of the vendors concerning the applicable requirements of this chapter prior to the

transaction of any personal electronics insurance. The training required by the provisions of this section shall comply with the following:

(i) The training shall be delivered to employees and authorized representatives of a vendor who are directly engaged in the activity of selling or offering portable electronics insurance;

(ii) The training may be provided in electronic form. However, if conducted in an electronic form, the supervising entity shall implement a supplemental education program regarding the portable electronics insurance product being offered or sold that is conducted and overseen by employees of the supervising entity that are licensed pursuant to this chapter;

(iii) Each employee and authorized representative shall receive basic instruction concerning the portable electronics insurance offered to customers and the disclosures required pursuant to section 41-1084, Idaho Code; and

(c) No employee or authorized representative of a vendor of portable electronics shall advertise, represent or otherwise hold himself out as a limited lines or other licensed insurance producer.

(2) The charges for portable electronics insurance coverage may be billed and collected by the vendor of portable electronics. Any charge to the enrolled customer for portable electronics insurance coverage that is not included in the cost associated with the purchase or lease of portable electronics or related services shall be separately itemized on the enrolled customer's bill. If the portable electronics insurance coverage is included with the purchase or lease of portable electronics or related services, the vendor shall clearly and conspicuously disclose to the enrolled customer that the portable electronics insurance coverage is included in the portable electronics or related services purchased. Vendors billing and collecting such charges shall not be required to maintain such funds in a segregated account, provided that the vendor is authorized by the insurer to hold such funds in a nonsegregated account and is required to remit such amounts to the supervising entity within sixty (60) days of receipt. All funds received by a vendor from an enrolled customer for the sale of portable electronics insurance shall be considered funds held in trust by the vendor in a fiduciary capacity for the benefit of the insurer. Failure to do so is a violation of this section. Vendors may receive compensation for billing and collection services.

History.
I.C., § 41-1085, as added by 2012, ch. 226, § 7, p. 619.

STATUTORY NOTES

Effective Dates.
Section 16 of S.L. 2012, ch. 206 provided that the act should take effect on and after July 1, 2013.

41-1086. Responsibility for actions of others. [Effective July 1, 2013.] — For purposes of licensing and regulation under title 41, Idaho Code, a portable electronics limited lines licensee shall be responsible for the

actions of the licensee's employees and authorized representatives acting on the licensee's behalf in relation to portable electronics insurance transactions and matters arising out of the same. Any violation of this chapter by the licensee's employees and authorized representatives acting on the licensee's behalf shall be considered a violation by the licensee.

History.
I.C., § 41-1086, as added by 2012, ch. 226, § 8, p. 619.

STATUTORY NOTES

Effective Dates.
Section 16 of S.L. 2012, ch. 206 provided that the act should take effect on and after July 1, 2013.

41-1087. Suspension or revocation of license. [Effective July 1, 2013.] — If a vendor of portable electronics or its employee or authorized representative violates any applicable provision of this chapter including, but not limited to, section 41-1016, Idaho Code, or applicable provisions of chapter 13, title 41, Idaho Code, or an applicable rule, the director may:

(1) Impose an administrative penalty pursuant to section 41-117, Idaho Code. However, penalties arising from the same or similar conduct shall not exceed fifty thousand dollars ($50,000) in the aggregate; and

(2) Impose other penalties that the director deems necessary and reasonable, including:

(a) Prohibiting such vendor from transacting portable electronics insurance pursuant to the provisions of this section at specific business locations where violations have occurred or from using specific employees or representatives in the transaction of portable electronics insurance; and

(b) Suspending, revoking or refusing to renew the license of such vendor.

History.
I.C., § 41-1087, as added by 2012, ch. 226, § 9, p. 619.

STATUTORY NOTES

Effective Dates.
Section 16 of S.L. 2012, ch. 206 provided that the act should take effect on and after July 1, 2013.

41-1088. Termination of portable electronics insurance. [Effective July 1, 2013. — Notwithstanding any other provision of law:

(1) An insurer may terminate or otherwise change the terms and conditions of a policy of portable electronics insurance only upon providing the policyholder and enrolled customers with at least thirty (30) days' notice.

(2) If the insurer changes the terms and conditions, then the insurer shall provide the vendor policyholder with a revised policy or endorsement and each enrolled customer with a revised certificate, endorsement, updated brochure or other evidence indicating that a change in the terms and conditions has occurred and a summary of material changes. An enrolled

customer shall be entitled to reject any change to the terms and conditions or cancel coverage, and the person who paid the premium shall receive a pro rata refund or credit of any applicable unearned premium within sixty (60) days of the receipt of notice from the customer that he wishes to cancel coverage.

(3) Notwithstanding subsection (1) of this section, an insurer may terminate an enrolled customer's enrollment under a portable electronics insurance policy upon fifteen (15) days' notice for discovery of fraud or material misrepresentation in obtaining coverage or in the presentation of a claim thereunder.

(4) Notwithstanding subsection (1) of this section, an insurer may immediately terminate an enrolled customer's enrollment under a portable electronics insurance policy:

(a) For nonpayment of premium;

(b) If the enrolled customer ceases to have an active service with the vendor of portable electronics; or

(c) If an enrolled customer exhausts the aggregate limit of liability under the terms of the portable electronics insurance policy and the insurer sends notice of termination to the enrolled customer within thirty (30) calendar days after exhaustion of the limit. However, if notice is not timely sent, enrollment shall continue notwithstanding the aggregate limit of liability until the insurer sends notice of termination to the enrolled customer and specifies the date of such termination.

(5) Where a portable electronics insurance policy is terminated by a policyholder, the policyholder shall mail or deliver written notice to each enrolled customer advising the enrolled customer of the termination of the policy and the effective date of termination. The written notice shall be mailed or delivered to the enrolled customer at least thirty (30) days prior to the termination, and any unearned premium shall be returned to the policyholder within sixty (60) days of such termination.

(6) An enrolled customer may cancel enrollment for coverage under a portable electronics insurance policy at any time, and the person paying the premium shall receive a pro rata refund or credit of any applicable unearned premium within sixty (60) days of the receipt of notice of cancellation from the customer.

(7) Whenever notice or correspondence with respect to a policy of portable electronics insurance is required pursuant to the provisions of this section or is otherwise required by law, it shall be in writing and sent within the required notice period, if any, specified within the statute or regulation requiring the notice or correspondence. Notwithstanding any other provision of law, notices and correspondence may be sent either by mail or by electronic means if agreed to by the customer pursuant to section 28-50-105, Idaho Code, and as set forth in this subsection. If the notice or correspondence is mailed, it shall be sent to the vendor of portable electronics at the vendor's mailing address specified for such purpose and to each affected enrolled customer's last known mailing address on file with the insurer. The insurer or vendor of portable electronics, as the case may be, shall maintain proof of mailing in a form authorized or accepted by the United States postal

service or other commercial mail delivery service. If the notice or correspondence is sent by electronic means, it shall be sent to the vendor of portable electronics at the vendor's electronic mail address specified for such purpose and to each affected enrolled customer's last known electronic mail address as provided by each enrolled customer to the insurer or vendor of portable electronics at the time of purchase of the portable electronics insurance coverage. For purposes of this subsection, an enrolled customer's provision of an electronic mail address to the insurer or vendor of portable electronics shall be deemed consent to receive notices and correspondence by electronic means at such address so long as notice of that consent is simultaneously provided to the customer. The insurer or vendor of portable electronics shall maintain proof that the notice or correspondence was sent.

(8) Notice or correspondence required by this section or otherwise required by law may be sent on behalf of an insurer or vendor by the supervising entity appointed by the insurer.

History.
I.C., § 41-1088, as added by 2012, ch. 226, § 10, p. 619.

STATUTORY NOTES

Effective Dates.
Section 16 of S.L. 2012, ch. 206 provided that the act should take effect on and after July 1, 2013.

41-1089. Application for license and fees. [Effective July 1, 2013.] — (1) A sworn application for a limited lines license to sell, solicit or negotiate portable electronics insurance shall be completed and filed with the department of insurance on forms prescribed by the director to include such information as the director deems necessary.

(2) The application shall:

(a) Provide the name, residence address and other information required by the director for an employee or officer of the vendor that is designated by the applicant as the person responsible for the vendor's compliance with the requirements of this chapter, which designation shall satisfy the requirements of section 41-1007(2)(b), Idaho Code. However, if the vendor derives more than fifty percent (50%) of its revenue from the sale of portable electronics insurance, the information noted in this subsection shall be provided for all officers, directors, and shareholders of record having beneficial ownership of ten percent (10%) or more of the vendor;

(b) Provide the location of the applicant's home office, both street address and mailing address, and phone number where such applicant may be reached during regular business hours; and

(c) Provide the syllabus for the training program that is developed by the supervising entity or the insurer that issued the portable electronics insurance policy to the vendor.

(3) Any vendor engaging in portable electronics insurance transactions on or before the effective date of sections 41-1081 through 41-1089, Idaho Code, must apply for licensure within ninety (90) days of the application being made available to the vendor by the director. Any applicant commenc-

ing operations after the effective date of sections 41-1081 through 41-1089, Idaho Code, must obtain a license prior to offering or selling portable electronics insurance.

(4) Notwithstanding any other provision of law, applicants for licensure pursuant to sections 41-1081 through 41-1089, Idaho Code, whose home state does not issue a producer license with a similar line of authority as the license authorized by such sections shall be issued a portable electronics limited lines license upon satisfying all applicable requirements of this chapter. However, any licensee whose home state does not authorize a limited lines license for portable electronics insurance in its home state after July 1, 2014, or such later date as may be determined by the director, shall obtain a property and casualty license under title 41, Idaho Code, or its license shall terminate in Idaho. For the purposes of this subsection, "home state" means the District of Columbia and any state or territory of the United States except Idaho, or any province of Canada, in which an applicant maintains such person's principal place of residence or principal place of business.

(5) Initial licenses issued pursuant to sections 41-1081 through 41-1089, Idaho Code, shall be valid for a period of twenty-four (24) months and expire thereafter unless renewed by the director upon completion of forms required by the director and payment of fees consistent with the provisions of this chapter.

(6) Each vendor of portable electronics licensed pursuant to this chapter shall pay to the director a fee of one thousand dollars ($1,000) for an initial portable electronics limited lines license and five hundred dollars ($500) for each renewal thereof. However, for a vendor engaged in portable electronics transactions at ten (10) or fewer locations in the state of Idaho, the fee shall not exceed one hundred dollars ($100) for an initial license and for each renewal thereof.

History.
I.C., § 41-1089, as added by 2012, ch. 226, § 11, p. 619.

STATUTORY NOTES

Effective Dates.
Section 16 of S.L. 2012, ch. 206 provided that the act should take effect on and after July 1, 2013.

CHAPTER 11

ADJUSTERS

41-1102. "Adjuster" defined. [Effective July 1, 2013.] — (1) An "adjuster" is a person who, on behalf of the insurer, for compensation as an

independent contractor or as the employee of such an independent contractor, or for fee or commission, investigates and negotiates settlement of claims arising under insurance contracts.

(2) None of the following is an "adjuster" for the purposes of this chapter:

(a) A licensed attorney at law who is qualified to practice law in this state.

(b) The salaried employee of an authorized insurer, or group of such insurers under common control or ownership, or of a managing general agent, who adjusts losses for such insurer or insurers or for the authorized insurers represented by the general agent.

(c) The licensed agent of an authorized insurer who, at the insurer's request, from time to time adjusts or assists in adjustment of losses arising under policies issued by such insurer.

(d) An individual who collects claim information from, or furnishes claim information to, claimants or those who are insured and who conducts data entry, including entering data into an automated claims adjudication system, provided that the individual is an employee of a licensed adjuster or its affiliate where no more than twenty-five (25) such persons are under the supervision of one (1) licensed adjuster or licensed agent. A licensed agent who acts as a supervisor or adjusts claims pursuant to the provisions of this paragraph is not required to also be licensed as an adjuster. For purposes of this section, "automated claims adjudication system" means a pre-programmed computer system designed for the collection, data entry, calculation and final resolution of portable electronics insurance claims that:

(i) May only be utilized by a licensed adjuster, licensed agent or supervised individuals operating pursuant to the provisions of this paragraph;

(ii) Must comply with all claims payment requirements of the insurance code; and

(iii) Must be certified as compliant with this section by a licensed adjuster who is an officer of a licensed business entity pursuant to the provisions of this chapter.

History.
1961, ch. 330, § 238, p. 645; am. 2012, ch. 226, § 12, p. 619.

STATUTORY NOTES

Amendments.
The 2012 amendment, by ch. 226, added paragraph (2)(d).

Compiler's Notes.
For this section as effective until July 1, 2013, see the bound volume.

Effective Dates.
Section 16 of S.L. 2012, ch. 206 provided that the act should take effect on and after July 1, 2013.

41-1103. License required. [Effective July 1, 2013.] — No person shall in this state be, act as, or advertise or hold himself out to be, an adjuster unless then licensed as an adjuster under this chapter. No resident of Canada may be licensed as a resident adjuster or may designate Idaho as

his home state, unless such person has successfully passed the adjuster examination and has complied with the other applicable provisions of this chapter. No resident of Canada may be licensed as a nonresident adjuster unless such person has obtained a resident or home state adjuster license in another state.

History.
1961, ch. 330, § 239, p. 645; am. 2012, ch. 226, § 13, p. 619.

STATUTORY NOTES

Amendments.
The 2012 amendment, by ch. 226, added the second and third sentences.

Compiler's Notes.
For this section as effective until July 1, 2013, see the bound volume.

Effective Dates.
Section 16 of S.L. 2012, ch. 206 provided that the act should take effect on and after July 1, 2013.

41-1104. Qualifications for adjuster's license. [Effective July 1, 2013.] — (1) Except as provided in subsection (2) of this section, the director shall not issue, continue, or permit to exist any license as an adjuster as to any person not qualified therefor as follows:

(a) Must be a natural person not less than twenty-one (21) years of age.

(b) Must be trustworthy, and be of good character and reputation as to morals, integrity, and financial responsibility, and must not have been convicted of a felony or of any crime involving moral turpitude.

(c) Must be a salaried employee of a licensed adjuster, or must have had experience or special education or training as to the investigation and settlement of loss of claims under insurance contracts of sufficient duration and extent reasonably to satisfy the director as to his competence to fulfill the responsibilities of an adjuster.

(d) If required by the director, must pass a written examination to test his knowledge of the duties and responsibilities of an adjuster and of matters involved in transactions under an adjuster's license. The examination shall be subject to the same applicable provisions as apply pursuant to title 41, Idaho Code, to examinations for license as insurance agent.

(2) A firm or corporation, whether or not organized under the laws of this state, may be licensed as an adjuster if each individual who is to exercise the license powers in this state is separately licensed, or is named in the firm or corporation license, and is qualified as for an individual license as adjuster under subsection (1) of this section. An additional full license fee shall be paid as to each individual in excess of one (1) so named in the firm or corporation license to exercise its powers.

History.
1961, ch. 330, § 240, p. 645; am. 1969, ch. 214, § 38, p. 625; am. 2012, ch. 226, § 14, p. 619.

STATUTORY NOTES

Amendments.

The 2012 amendment, by ch. 226, substituted "pursuant to title 41, Idaho Code" for "under this code" in paragraph (1)(d) and made stylistic changes.

Compiler's Notes.

For this section as effective until July 1, 2013, see the bound volume.

Section 15 of S.L. 2012, ch. 226 provided: "Severability. The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act."

Effective Dates.

Section 16 of S.L. 2012, ch. 206 provided that the act should take effect on and after July 1, 2013.

CHAPTER 12

UNAUTHORIZED INSURERS AND SURPLUS LINES

41-1212. Exemptions from surplus line law. — (1) The provisions of this surplus line law controlling the placing of insurance with unauthorized insurers shall not apply to reinsurance or, except as to subsection (2) below, to the following insurances when so placed by licensed agents or surplus line brokers of this state:

(a) Ocean marine and foreign trade insurances.

(b) Insurance on subjects located, resident, or to be performed wholly outside of this state, or on vehicles or aircraft owned and principally garaged outside this state.

(c) Insurance on operations of railroads engaged in transportation in interstate commerce and their property used in such operations.

(d) Insurance of aircraft owned or operated by manufacturers of aircraft, or of aircraft operated in commercial scheduled interstate flight, or cargo of such aircraft, or against liability, other than worker's compensation and employer's liability, arising out of the ownership, maintenance or use of such aircraft.

(2) Brokers so placing any such insurance with an unauthorized insurer shall keep a full and true record of each such coverage in detail as required of surplus line insurance under this law. The record shall be preserved for not less than five (5) years from the effective date of the insurance and shall be kept available in this state and open to the examination of the director. The broker shall furnish to the director at his request and on forms as designated and furnished by him a report of all such coverages so placed in a designated calendar year.

(3) The following sections apply only when the insured's home state is Idaho:

(a) Section 41-1214, Idaho Code (conditions for export);

(b) Section 41-1215, Idaho Code (broker's affidavit);

(c) Section 41-1216, Idaho Code (open lines for export);

(d) Section 41-1217, Idaho Code (eligible surplus lines insurers);

(e) Section 41-1218, Idaho Code (eligible surplus line insurers — penalty for violation);
(f) Section 41-1219, Idaho Code (evidence of the insurance — changes — penalty);
(g) Section 41-1220, Idaho Code (endorsement of contract);
(h) Section 41-1227, Idaho Code (records of broker);
(i) Section 41-1228, Idaho Code (annual report of broker);
(j) Section 41-1229, Idaho Code (tax on surplus lines);
(k) Section 41-1233, Idaho Code (report and tax of independently procured coverages);
(*l*) Section 41-1234, Idaho Code (records of insureds).

History.
1961, ch. 330, § 256, p. 645; am. 1972, ch. 369, § 8, p. 1072; am. 2011, ch. 183, § 1, p. 517.

STATUTORY NOTES

Amendments.
The 2011 amendment, by ch. 183, substituted "worker's compensation" for "workmen's compensation" in paragraph (1)(d) and added subsection (3).

41-1213. Definitions. — As used in this chapter and any applicable rules, the following definitions shall apply:
(1) "Affiliated" means, with respect to an insured, any entity that controls, is controlled by or is under common control with the insured.
(2) "Affiliated group" means any group of entities that are all affiliated.
(3) "Broker" means a surplus line broker duly licensed as such under this chapter, including resident surplus line brokers and nonresident surplus line brokers.
(4) "Control" means:
(a) An entity directly or indirectly, or acting through one (1) or more other persons, owns or controls another entity or has the power to vote twenty-five percent (25%) or more of any class of voting securities of another entity; or
(b) An entity controls in any manner the election of a majority of the directors or trustees of another entity.
(5)(a) "Exempt commercial purchaser" means any person purchasing commercial insurance who, at the time of placement, meets the following requirements:
(i) The person employs or retains a qualified risk manager to negotiate insurance coverage.
(ii) The person has paid aggregate nationwide commercial property and casualty insurance premiums in excess of one hundred thousand dollars ($100,000) in the immediately preceding twelve (12) months.
(iii) The person meets at least one (1) of the following criteria:
1. The person possesses a net worth in excess of twenty million dollars ($20,000,000) as such amount is adjusted pursuant to the provisions of paragraph (b) of this subsection.
2. The person generates annual revenues in excess of fifty million

dollars ($50,000,000) as such amount is adjusted pursuant to the provisions of paragraph (b) of this subsection.

3. The person employs more than five hundred (500) full-time or full-time equivalent employees per individual insured or is a member of an affiliated group employing more than one thousand (1,000) employees in the aggregate.

4. The person is a nonprofit organization or public entity generating annual budgeted expenditures of at least thirty million dollars ($30,000,000) as such amount is adjusted pursuant to the provisions of paragraph (b) of this subsection.

5. The person is a municipality with a population in excess of fifty thousand (50,000) persons.

(b) The amounts provided in subparagraph (iii)1., 2. and 4. of paragraph (a) of this subsection must be adjusted to reflect the percentage change for the five (5) year period in the consumer price index for all urban consumers published by the bureau of labor statistics of the United States department of labor.

(c) For the purposes of this subsection, "commercial insurance" means property and casualty insurance pertaining to a business, profession, occupation, nonprofit organization or public entity.

(6) "Export" means to place in an unauthorized insurer under this surplus line law insurance covering a subject of insurance resident, located, or to be performed in Idaho.

(7)(a) "Home state" means:

(i) The state in which an insured maintains its principal place of business or, in the case of an individual, the individual's principal residence; or

(ii) If one hundred percent (100%) of the insured risk is located out of state, the state to which the greatest percentage of the insured's taxable premium for that insurance contract is allocated.

(b) If more than one (1) insured from an affiliated group are named insureds on a single nonadmitted insurance contract, then "home state" means the home state, as determined pursuant to the provisions of paragraph (a) of this subsection, of the member of the affiliated group that has the largest percentage of premium attributed to it under such insurance contract.

(c) For the purposes of this subsection, "principal place of business" means the state where the insured maintains its headquarters and where the insured's high level officers direct, control and coordinate the business activities of the insured.

(8) "Qualified risk manager" means, with respect to a policyholder of commercial insurance, a person who meets all of the following requirements:

(a) The person is an employee of, or a third party consultant retained by, the commercial policyholder;

(b) The person provides skilled services in loss prevention, loss reduction or risk and insurance coverage analysis, and purchase of insurance; and

(c) The person:

(i) Has at least ten (10) years of experience in risk financing, claim administration, loss prevention, risk and insurance coverage analysis or purchasing commercial lines of insurance; or

(ii) Has a graduate degree from an accredited college or university in risk management, business administration, finance, economics or any other field determined by a state insurance director or other state regulatory official or entity to demonstrate minimum competence in risk management; or

(iii) Has at least seven (7) years of experience in risk financing, claims administration, loss prevention, risk and insurance coverage analysis or purchasing commercial lines of insurance and has one (1) of the designations specified in subparagraph (iv)1. through 5. of this paragraph; or

(iv) Has a bachelor's degree or higher education from an accredited college or university in risk management, business administration, finance, economics or any other field determined by a state insurance director or other state regulatory official or entity to demonstrate minimum competency in risk management; and either has three (3) years of experience in risk financing, claims administration, loss prevention, risk and insurance analysis or purchasing commercial lines of insurance, or has one (1) of the following designations:

1. A designation as a chartered property and casualty underwriter (CPCU) issued by the American institute for CPCU and insurance institute of America;

2. A designation as an associate in risk management (ARM) issued by the American institute for CPCU and insurance institute of America;

3. A designation as a certified risk manager (CRM) issued by the national alliance for insurance education and research;

4. A designation as a RIMS fellow (RF) issued by the global risk management institute; or

5. Any other designation, certification or license determined by a state insurance director or other state insurance regulatory official or entity to demonstrate minimum competency in risk management.

History.
1961, ch. 330, § 257, p. 645; am. 2002, ch. 91, § 2, p. 227; am. 2011, ch. 183, § 2, p. 517.

STATUTORY NOTES

Amendments.
The 2011 amendment, by ch. 183, added the introductory language; added subsections (1) and (2); redesignated former subsection (1) as subsection (3), and therein deleted "as used in this chapter" following "'Broker'"; added subsection (4); redesignated former subsection (2) as subsection (6), and therein substituted "'Export'" for "To 'export'"; and added subsections (7) and (8).

41-1214. Conditions for export. — If certain insurance coverages cannot be procured from authorized insurers, such coverages, hereinafter

designated "surplus lines," may be procured from unauthorized insurers, subject to the following conditions:

(1) The insurance must be procured through a licensed surplus line broker who is a member of a surplus line association approved by the director.

(2) The full amount or kind of insurance required must not be procurable from insurers who are authorized to do business in this state. The amount of insurance exported shall be only the excess over the amount procurable from authorized insurers unless the excess is not available without support of other coverages, provided that a diligent search is made among the insurers authorized to transact and actually writing that particular kind and class of insurance in this state.

(3) The insurance must not be so exported for the purpose of securing advantages either as to:

(a) A lower premium rate than would be accepted by an authorized insurer; or

(b) Terms of the insurance contract.

(4) A surplus line broker seeking to procure from or place insurance with an unauthorized insurer for an exempt commercial purchaser is not required to satisfy the diligent search requirement set forth in subsection (2) of this section when:

(a) The surplus line broker or referring insurance producer procuring or placing the surplus line insurance has disclosed to the exempt commercial purchaser that such insurance may or may not be available from the admitted market that may provide greater protection with more regulatory oversight; and

(b) The exempt commercial purchaser has subsequently requested in writing the surplus line broker or referring insurance producer to procure or place such insurance from an unauthorized insurer.

(5) Records of the surplus line broker's satisfaction of the requirements of subsection (4) of this section shall be maintained in compliance with the provisions of section 41-1227, Idaho Code.

(6) A surplus line broker may not knowingly place surplus line insurance with insurers that are financially unsound. The surplus line broker may only so insure with the following:

(a) Any foreign insurer that is authorized to write the kind of insurance in its domiciliary jurisdiction and has capital and surplus or its equivalent under the laws of its domiciliary jurisdiction that equals the greater of the following: (i) the minimum capital and surplus requirements under the laws of this state; or (ii) fifteen million dollars ($15,000,000); or

(b) Any alien insurer that is listed on the quarterly listing of alien insurers maintained by the international insurers department of the national association of insurance commissioners.

(7) The requirements in paragraph (a) of subsection (6) of this section may be satisfied by an insurer that possesses less than the minimum capital and surplus upon an affirmative finding of acceptability by the director. Such finding shall be based upon factors such as quality of management, capital and surplus of any parent company, company underwriting profit

and investment income trends, market availability and company record and reputation within the industry. The director is prohibited from making an affirmative finding of acceptability when the foreign insurer's capital and surplus is less than four million five hundred thousand dollars ($4,500,000).

(8) The director may promulgate rules to prescribe the terms under which the financial requirements provided in this section may be waived in circumstances where insurance cannot be otherwise procured on risks located in this state.

(9) For any violation of the provisions of this section, a surplus line broker may be subject to a fine of not less than one hundred dollars ($100) and not more than five thousand dollars ($5,000), or the surplus line broker's license may be revoked, suspended or nonrenewed, or both such fine and license revocation, suspension or nonrenewal.

History.
1961, ch. 330, § 258, p. 645; am. 1993, ch. 22, § 2, p. 79; am. 2011, ch. 183, § 3, p. 517.

STATUTORY NOTES

Amendments.
The 2011 amendment, by ch. 183, added subsections (4) through (9).

41-1223. Licensing of surplus line brokers. — (1) Any individual while licensed as a producer licensed for property or casualty insurance who has had at least two (2) years' experience as a producer for the lines of insurance for which he is seeking to be licensed as a surplus line broker, and who is deemed by the director to be competent and trustworthy with respect to the handling of surplus lines, may be licensed as a surplus line broker.

(2) Application for the license shall be made to the director on forms as designated and furnished by the director.

(3) The license and continuation fee shall be as set forth by rule pursuant to section 41-401, Idaho Code.

(4) The license and licensee shall be subject to the applicable provisions of chapter 10, title 41, Idaho Code (producer licensing).

(5) When a national insurance producer database of the national association of insurance commissioners, or other equivalent uniform national database, for the licensure of surplus line brokers is created, the director may participate in such database.

History.
1961, ch. 330, § 267, p. 645; am. 1972, ch. 164, § 3, p. 376; 1976, ch. 118, § 3, p. 456; am. 2001, ch. 296, § 5, p. 1044; am. 2002, ch. 91, § 7, p. 227; am. 2011, ch. 183, § 4, p. 517.

STATUTORY NOTES

Amendments.
The 2011 amendment, by ch. 183, added subsection (5).

41-1229. Tax on surplus lines. — (1) On or before the first day of

March of each year each broker shall remit to the director a tax on the premiums, exclusive of sums collected to cover federal and state taxes and examination fees, on surplus line insurance subject to tax transacted by him with unauthorized insurers during the preceding calendar year as shown by his annual statement filed with the director, and at the rate of one and five-tenths percent (1.5%). Such tax shall be in lieu of all other taxes upon such insurers with respect to the business so reported.

(2) For property and casualty insurance other than worker's compensation insurance, if Idaho is the insured's home state, then the tax so payable shall be computed upon the entire premium under subsection (1) of this section, without regard to whether the policy covers risks or exposures that are located in Idaho. For all other lines of insurance, if a surplus line policy covers risks or exposures only partially in Idaho, the tax so payable shall be computed upon the proportion of the premium that is properly allocable to the risks or exposures located in Idaho.

History.

1961, ch. 330, § 273, p. 645; am. 1988, ch. 186, § 1, p. 325; am. 1988, ch. 366, § 4, p. 1077; am. 1994, ch. 383, § 3, p. 1229; am. 2004, ch. 387, § 1, p. 1163; am. 2011, ch. 183, § 5, p. 517.

STATUTORY NOTES

Amendments.

The 2011 amendment, by ch. 183, in subsection (1), substituted "and at the rate of one and five-tenths percent (1.5%)" for "and at the following rates" and deleted paragraphs (1)(a) and (1)(b), which concerned calendar years 2004 through 2007; and rewrote subsection (2), which formerly read: "If a surplus line policy covers risks or exposure only partially in this state, the tax so payable shall be computed upon the proportion of the premium which is properly allocable to the risks or exposures located in this state."

Effective Dates.

Section 6 of S.L. 2011, ch. 183 provided that the amendment of § 41-1229 should take effect on and after July 21, 2011.

CHAPTER 13

TRADE PRACTICES AND FRAUDS

SECTION.

41-1314. Rebates — Illegal inducements. — (1) Except as otherwise expressly provided by law, no person shall knowingly make, permit to be made, or offer to make any contract of insurance, or of annuity, or agreement as to such contract, other than as plainly expressed in the contract issued thereon, or pay or allow, or give or offer to pay, allow, or give, directly or indirectly, as inducement to such insurance or annuity or in connection therewith, any rebate of premiums payable on the contract, or of any producer's commission related thereto, or any special favor or advantage in the dividends or other benefits thereon, or any paid employment or contract for services of any kind, or any valuable consideration or inducement whatever not specified in the contract; or directly or indirectly give, or sell, or purchase or offer or agree to give, sell, purchase, or allow as inducement to such insurance or annuity or in connection therewith, and whether or not

specified or to be specified in the policy or contract, any agreement of any form or nature promising returns and profits, or any stocks, bonds, or other securities, or interest present or contingent therein or as measured thereby, of any insurer or other person, or any dividends or profits accrued or to accrue thereon; or offer, promise or give anything of value whatsoever not specified in the contract. Nor shall any insured, annuitant, or policyholder or employee thereof, or prospective insured, annuitant or policyholder, or employee thereof, knowingly accept or receive, directly or indirectly, any such prohibited contract, agreement, rebate, advantage, employment, or other inducement.

(2) Nothing in this section shall be construed as prohibiting the payment of commissions or other compensation to duly licensed producers, or as prohibiting any insurer from allowing or returning to its participating policyholders, members or subscribers, the usual and ordinary dividends, savings, or unabsorbed premium deposits.

(3) Nothing in this section shall be construed as prohibiting a life insurer, disability insurer, property insurer or casualty insurer, or producers who are marketing life insurance, disability insurance, property insurance or casualty insurance, from providing to a policyholder or prospective policyholder of life, disability, property or casualty insurance, any prizes, goods, wares, merchandise, articles or property of an aggregate value not to exceed two hundred dollars ($200) in a calendar year.

(4) Extension of credit for the payment of premium beyond the customary premium payment period without charging and collecting interest at a reasonable rate per annum on the amount of credit so extended and for the duration of such credit is prohibited under this section.

History.
1961, ch. 330, § 292, p. 645; am. 1969, ch. 214, § 46, p. 625; am. 2006, ch. 212, § 1, p. 643; am. 2011, ch. 259, § 1, p. 704.

STATUTORY NOTES

Amendments.
The 2011 amendment, by ch. 259, in subsection (1), substituted "producer's commission" for "agent's, solicitor's, or broker's commission"; in subsection (2), substituted "producers" for "agents, solicitors, or brokers"; and, in subsection (3), inserted "disability insurer," "disability insurance," and "disability" and substituted "aggregate value not to exceed two hundred dollars ($200) in a calendar year" for "aggregate value of fifty dollars ($50.00) or less."

41-1329. Unfair claim settlement practices.

JUDICIAL DECISIONS

Action in Tort by Insured.
In a suit stemming from an insurer's bad faith breach of contract, the trial court did not err in instructing the jury on this chapter, because such instruction did not, as the insurer argued, change the chapter from potential evidence of the industry standard to the law governing bad faith claims. Nowhere in its jury instruction did the court imply that the stutute created a private right of action. Weinstein v. Prudential Prop. & Cas. Ins. Co., 149 Idaho 299, 233 P.3d 1221 (2010).

CHAPTER 16

WORKER'S COMPENSATION RATES

CHAPTER 18

THE INSURANCE CONTRACT

41-1811. Representations in applications.

RESEARCH REFERENCES

A.L.R. — Rescission of directors' and officers' liability insurance policy. 29 A.L.R.6th 189.

41-1823. Binders. — (1) Binders or other contracts for temporary insurance may be made orally or in writing and shall be deemed to include all the usual terms of the policy as to which the binder was given together with such supplemental information and applicable endorsements as are designated in the binder, except as superseded by the clear and express terms of the binder.

(2) No binder shall be valid beyond the issuance of the policy, or the endorsement, or the policy expiration, whichever is shortest, with respect to which it was given.

(3) This section shall not apply to life or disability insurances.

History.
1961, ch. 330, § 415, p. 645; am. 2012, ch. 314, § 2, p. 863.

STATUTORY NOTES

Amendments.
The 2012 amendment, by ch. 314, inserted "supplemental information and" in subsection (1); substituted "or the endorsement, or the policy expiration, whichever is shortest, with respect to which it was given" for "with respect to which it was given or beyond ninety (90) days from its effective date, whichever period is the shorter"; deleted former subsection (3), which read, "If the policy has not been issued a binder may be extended or renewed beyond such ninety (90) days with the written approval of the director, or in accordance with such rules and regulations relative thereto as the director may promulgate."; and renumbered former subsection (4) as present subsection (3).

Compiler's Notes.
Section 3 of S.L. 2012, ch. 314 provided "Severability. The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act."

41-1839. Allowance of attorney's fees in suits against or in arbitration with insurers.

JUDICIAL DECISIONS

ANALYSIS

Appeal not frivolous.
Attorney fees.
Duty of claimant.
Justly due.
Prevailing party.
Voluntary payment.

Appeal Not Frivolous.

Subsection (4) authorizes an award of attorney fees if an appeal is brought frivolously: such as when an appellant is merely asking the supreme court to second-guess the district court's ruling, despite unambiguous controlling language in the insurance policy. Mortensen v. Stewart Title Guar. Co., 149 Idaho 437, 235 P.3d 387 (2010).

Attorney Fees.

Where appellant insured's suit against respondent insurance company for breach of an insurance contract and declaratory relief was dismissed and the supreme court upheld the decision, although the insurance company prevailed on appeal, subsection (4) of this section precluded an award of attorney fees. Villa Highlands, LLC v. Western Cmty. Ins. Co., 148 Idaho 598, 226 P.3d 540 (2010).

This section and § 12-123 are the exclusive remedies for obtaining attorney fees in insurance disputes. The award of fees was proper where the insured never raised any triable issues of fact and did not attempt to offer any factual evidence to support his claims that the title company acted without diligence or in bad faith when it sought to obtain for him an ownership interest in the access road, even though he demanded that the title company do something to ensure he had an easement there. Mortensen v. Stewart Title Guar. Co., 149 Idaho 437, 235 P.3d 387 (2010).

In a suit stemming from an insurer's bad faith failure to pay medical bills of its innocent insureds who were injured in an automobile collision, the trial court erred in awarding attorney fees under subsection (1) of this section based upon the insurer's failure to pay for an insured's future medical expenses or general damages because the insureds never submitted a proof of loss for such damages and, thus, failed to meet the condition precedent for an award of attorney fees for recovering those damages. Because the insureds only submitted claims for past medical services received and did not submit a claim for future medical expenses, the insurer did not act in bad faith in failing to pay future medical expenses. Weinstein v. Prudential Prop. & Cas. Ins. Co., 149 Idaho 299, 233 P.3d 1221 (2010).

Duty of Claimant.

If a party claims this section provides authority for an award of attorney's fees, the party must cite to the section and, if applicable, the specific subsection, upon which the party relies or attorney's fees will not be awarded. Rogers v. Household Life Ins. Co., 150 Idaho 735, 250 P.3d 786 (2011).

Justly Due.

Under this section, no amount is "justly due" until facts substantially indicative of the uninsured motorist's liability are shown the insurer Jones v. State Farm Mut. Auto Ins. (In re Jones), 2009 Bankr. LEXIS 5520 (D. Idaho June 22, 2009).

Prevailing Party.

Where appellant insured's suit for breach of an insurance contract and declaratory relief was dismissed, the insured was not the prevailing party and was not entitled to recover attorney fees under subsection (1) of this section or subsection (3) of § 12-120. Villa Highlands, LLC v. Western Cmty. Ins. Co., 148 Idaho 598, 226 P.3d 540 (2010).

Voluntary Payment.

Any right an insurer has to contest the amount "justly due" is waived upon its voluntary payment of a greater amount. Jones v. State Farm Mut. Auto Ins. (In re Jones), 2009 Bankr. LEXIS 5520 (D. Idaho June 22, 2009).

Cited in: Hill v. Am. Family Mut. Ins. Co., 150 Idaho 619, 249 P.3d 812 (2011).

41-1848. Legislative findings and purpose — Coverage for abortions in state exchange prohibited. — (1) The legislature finds that:

(a) Pursuant to section 1303 of the patient protection and affordable care

act, P.L. 111-148, states are explicitly permitted to pass laws prohibiting qualified health plans offered through an exchange in their state from offering abortion coverage;

(b) It is the longstanding policy of this state to prefer live childbirth over abortion and to prohibit the use of taxpayer moneys to fund abortions unless the mother's life is at risk or the pregnancy is a result of rape or incest;

(c) Idaho law prohibits certain insurance plans, policies and contracts issued in this state from offering coverage for elective abortions; and

(d) It is the purpose of this section to affirmatively prohibit qualified health plans that cover abortions from participating in exchanges within this state.

(2) Notwithstanding any other provision of law, no abortion coverage may be provided by a qualified health plan offered through an exchange created pursuant to the patient protection and affordable care act, P.L. 111-148, within the state of Idaho.

(3) The provisions of subsection (2) of this section shall not apply to an abortion performed if it is the recommendation of one (1) consulting physician that an abortion is necessary to save the life of the mother, or if the pregnancy is a result of rape, as defined in section 18-6101, Idaho Code, or incest as determined by the courts.

History.
I.C., § 41-1848, as added by 2011, ch. 152, § 1, p. 436.

STATUTORY NOTES

Federal References.
P.L. 111-148, the patient protection and affordable care act, referred to in this section, is generally codified in title 42 of the United States Code. Section 1303 of the act, referred to in paragraph (1)(a), is codified as 42 USCS § 18023.

41-1850. Certificates of insurance. — (1) For purposes of this section, the following terms have the following meanings:

(a) "Certificate" or "certificate of insurance" means any document or instrument, no matter how titled or described, which is prepared or issued as evidence of property or casualty insurance coverage. "Certificate" or "certificate of insurance" shall not include a policy of insurance, insurance binder, policy endorsement or automobile insurance identification card.

(b) "Certificate holder" means any person, other than a policyholder, that requests, obtains or possesses a certificate of insurance.

(c) "Insurance producer" has the same meaning as provided for in title 41, chapter 10, Idaho Code.

(d) "Insurer" has the same definition as provided for in section 41-103, Idaho Code.

(e) "Person" means any individual, partnership, corporation, association or other legal entity, including any government or governmental subdivision or agency.

(f) "Policyholder" means a person who has contracted with a property or casualty insurer for insurance coverage.

(g) "Group master policy" means an insurance policy that provides coverage to eligible persons on a group basis through a group insurance program.

(2) No person, wherever located, may prepare, issue or knowingly request the issuance of a certificate of insurance unless the form has been filed with the director by or on behalf of an insurer. No person, wherever located, may alter or modify a certificate of insurance form unless the alteration or modification has been filed with the director.

(3) The director shall disapprove the use of any form filed under this section, or withdraw approval of a form, if the form:

(a) Is unfair, misleading or deceptive, or violates public policy;

(b) Fails to comply with the requirements of this section; or

(c) Violates any provision of title 41, Idaho Code, including any rule promulgated by the director.

(4) Each certificate of insurance must contain the following or similar statement: "This certificate of insurance is issued as a matter of information only and confers no rights upon the certificate holder. This certificate does not alter, amend or extend the coverage, terms, exclusions and conditions afforded by the policies referenced herein."

(5) The current edition of standard certificate of insurance forms promulgated and filed with the director by the association for cooperative operations research and development (ACORD) or the insurance services office (ISO) are not required to be refiled by individual insurers.

(6) No person, wherever located, shall demand or request the issuance of a certificate of insurance or other document, record or correspondence that the person knows contains any false or misleading information or that purports to affirmatively or negatively alter, amend or extend the coverage provided by the policy of insurance to which the certificate makes reference.

(7) No person, wherever located, may knowingly prepare or issue a certificate of insurance or other document, record or correspondence that contains any false or misleading information or that purports to affirmatively or negatively alter, amend or extend the coverage provided by the policy of insurance to which the certificate makes reference.

(8) The provisions of this section shall apply to all certificate holders, policyholders, insurers, insurance producers and certificate of insurance forms issued as evidence of property or casualty insurance coverages on property, operations or risks located in this state, regardless of where the certificate holder, policyholder, insurer or insurance producer is located.

(9) A certificate of insurance is not a policy of insurance and does not affirmatively or negatively alter, amend or extend the coverage afforded by the policy to which the certificate of insurance makes reference. A certificate of insurance shall not confer to a certificate holder new or additional rights beyond what the referenced policy of insurance provides.

(10) No certificate of insurance shall contain references to contracts other than the underlying contracts of insurance, including construction or service contracts. Notwithstanding any requirement, term or condition of

any contract or other document with respect to which a certificate of insurance may be issued or may pertain, the insurance afforded by the referenced policy of insurance is subject to all the terms, exclusions and conditions of the policy itself.

(11) A person is entitled to receive notice of cancellation, nonrenewal or any material change or any similar notice concerning a policy of insurance only if the person has such notice rights under the terms of the policy or any endorsement to the policy. The terms and conditions of the notice, including the required timing of the notice, are governed by the policy of insurance or endorsement and may not be altered by a certificate of insurance.

(12) Any certificate of insurance or any other document, record or correspondence prepared, issued or requested in violation of this section shall be null and void and of no force and effect.

(13) Any person who violates this section shall be subject to an administrative penalty imposed by the director in an amount as provided for in section 41-117, Idaho Code, per violation.

(14) The director shall have the power to examine and investigate the activities of any person that the director believes has been or is engaged in an act or practice prohibited by this section. The director shall have the power to enforce the provisions of this section and impose any authorized penalty or remedy against any person who violates this section.

(15) The director may, in accordance with section 41-211, Idaho Code, adopt reasonable rules as are necessary or proper to carry out the provisions of this section.

(16) This section shall not apply to any certificate of insurance prepared and/or issued by an insurer pursuant to any federal law, rule or regulation, or any other law, rule or regulation of this state, in which the specific content and form of said certificate is enumerated therein, or a certificate issued to a person or entity that has purchased coverage under a group master policy.

History.

I.C., § 41-1850, as added by 2012, ch. 314, § 1, p. 863.

STATUTORY NOTES

Compiler's Notes.

Section 3 of S.L. 2012, ch. 314 provided: "Severability. The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act."

The words enclosed in parentheses so appeared in the law as enacted.

CHAPTER 19

LIFE INSURANCE POLICIES AND ANNUITY CONTRACTS

SECTION.

41-1941. Annuity sales to consumers — Disclosures. — (1) In this section, the following definitions shall apply unless the context otherwise requires:

(a) "Contract owner" means the owner named in the annuity contract or certified holder in the case of a group annuity contract.

(b) "Determinable elements" means elements that are derived from processes or methods that are guaranteed at issue and that are not subject to company discretion, but where the values or amounts cannot be determined until some point after issue. These elements may include the premiums, credited interest rates (including any bonus), benefits, values, noninterest based credits, charges or elements of formulas used to determine any of these. An element is considered determinable if it is calculated from underlying determinable elements only or from both determinable and guaranteed elements.

(c) "Generic name" means a short title descriptive of the annuity contract being applied for or illustrated such as "single premium deferred annuity."

(d) "Guaranteed elements" means the premiums, credited interest rates (including any bonus), benefits, values, noninterest based credits, charges or elements of formulas used to determine any of these, that are promised and determined at issue. An element is considered guaranteed if all of the underlying elements that go into its calculation are guaranteed.

(e) "Insurance producer" or "producer" has the same meaning as in chapter 10, title 41, Idaho Code.

(f) "Nonguaranteed elements" means the premiums, credited interest rates (including any bonus), benefits, values, noninterest based credits, charges or elements of formulas used to determine any of these, that are subject to company discretion and that are not guaranteed at issue. An element is considered nonguaranteed if any of the underlying nonguaranteed elements are used in its calculation.

(g) "Structured settlement annuity" means a qualified funding asset as defined in section 130(d) of the Internal Revenue Code or an annuity that would be a qualified funding asset under section 130(d) of the Internal Revenue Code but for the fact that it is not owned by an assignee under a qualified assignment.

(2) The provisions of this section shall apply to all group and individual annuity contracts and certificates except:

(a) Registered or nonregistered variable annuities or other registered products;

(b) Immediate and deferred annuities that contain no nonguaranteed elements;

(c) Annuities used to fund:

(i) An employee pension plan that is covered by the employee retirement income security act of 1974, title 29, U.S.C. sections 1001 through 1461;

(ii) A plan described in section 401(a), 401(k) or 403(b) of the Internal Revenue Code, where the plan, for purposes of the employee retirement income security act of 1974, is established or maintained by an employer;

(iii) A governmental or church plan as defined in section 414 of the Internal Revenue Code or a deferred compensation plan of a state or local government or a tax exempt organization pursuant to section 457 of the Internal Revenue Code; or

(iv) A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor.

(d) Structured settlement annuities.

(3) If the application for an annuity contract is taken in a face-to-face meeting, the applicant, at or before the time of application, shall be given both the disclosure document and the buyer's guide in the form prescribed by the director. The disclosure document shall be dated and signed by the prospective annuity owner and producer and the company shall maintain a signed copy for the life of the contract.

(4) If the application for an annuity contract is taken by means other than in a face-to-face meeting, the applicant shall be sent both the disclosure document and the buyer's guide in the manner and form prescribed by the director no later than five (5) business days after the completed application is received by the insurer.

(5) A solicitation for an annuity contract provided in other than a face-to-face meeting shall include a statement that the proposed applicant may contact the insurer for a free annuity buyer's guide.

(6) If the disclosure document and buyer's guide are not provided at or before the time of application, a free look period of not less than twenty (20) days shall be provided for the applicant to return the annuity contract without penalty. This free look period shall run concurrently with any other free look period provided in statute.

(7) At minimum, the following information shall be included in the disclosure document required to be provided under this section:

(a) The generic name of the contract, the company product name, if different, the form number and the fact that it is an annuity;

(b) The insurer's name and address;

(c) A description of the contract and its benefits, emphasizing its long-term nature and including the following examples where appropriate:

(i) The guaranteed, nonguaranteed and determinable elements of the contract, their limitations, if any, and an explanation of how they operate;

(ii) An explanation of the initial crediting rate, specifying any bonus or introductory portion, the duration of the rate and the fact that rates may change from time to time and are not guaranteed;

(iii) The periodic income options both on a guaranteed and nonguaranteed basis;

(iv) Any value reductions caused by withdrawals from or surrender of the contract;

(v) How values in the contract can be accessed;

(vi) The death benefit, if available, and how it will be calculated;

(vii) A summary of the federal tax status of the contract and any penalties applicable on withdrawal of values from the contract; and

(viii) The impact of any rider, such as a long-term care rider.

(d) The specific dollar amount or percentage charges and fees shall be listed with an explanation of how they apply;

(e) Information about the current guaranteed rate for new contracts that contains a clear notice that the rate is subject to change;

(f) Whenever projections for nonguaranteed elements of a contract are provided in the disclosure document, equal prominence shall be given to guaranteed elements; and

(g) Terms used in the disclosure document shall be defined in clear and concise language that facilitates the understanding of a typical person within the segment of the public to which the disclosure document is directed.

(8) For annuities in the payout period with changes in nonguaranteed elements and for the accumulation period of a deferred annuity, the insurer shall provide each contract owner with a report, at least annually, on the status of the contract. Such report shall contain at minimum the following information:

(a) The beginning and end dates of the current report period;

(b) The accumulation and cash surrender value, if any, at the end of the previous report period and at the end of the current report period;

(c) The total amounts, if any, that have been credited, charged to the contract value or paid during the current report period; and

(d) The amount of outstanding loans, if any, as of the end of the current report period.

(9) The director may promulgate rules pursuant to this section including, but not limited to, more fully implementing model rules or laws developed by the national association of insurance commissioners that provide standards for the disclosure of certain minimum information in connection with the sale of annuity contracts.

(10) Nothing in this section shall be construed to create or imply a private cause of action for a violation of the provisions of this section or rules promulgated pursuant to this section.

History.

I.C., § 41-1941, as added by 2010, ch. 238, § 1, p. 617; am. 2012, ch. 107, § 6, p. 284.

STATUTORY NOTES

Amendments.

The 2012 amendment, by ch. 107 inserted "or" in paragraph (8)(c).

Federal References.

Section 130(d) of the Internal Revenue Code, referred to in paragraph (1)(g), is codified as 26 USCS § 130(d).

Sections 401(a), 401(k) and 403(b) of the Internal Revenue Code, referred to in paragraph (2)(c)(ii), are codified as 26 USCS §§ 401(a), 401(k), and 403(b).

Sections 414 and 457 of the Internal Revenue Code, referred to in paragraph (2)(c)(iii), are codified as 26 USCS §§ 414 and 457.

CHAPTER 25

CASUALTY INSURANCE CONTRACTS

SECTION.
41-2511. Deductible — Permissive.

41-2502. Uninsured motorist and underinsured motorist coverage for automobile insurance — Exceptions.

JUDICIAL DECISIONS

Exhaustion Clauses.
Because the exhaustion clause in the insured's policy with the insurer violated public policy, it could not bar her recovery for uninsured motorists benefits. Under this section, claimants need not exhaust the limits of the tortfeasor's policy, but instead had to credit to the UIM insurer the gap between the settlement with the tortfeasor's insurer, if any, and the policy limits. Hill v. Am. Family Mut. Ins. Co., 150 Idaho 619, 249 P.3d 812 (2011).

41-2511. Deductible — Permissive. — Nothing in sections 41-2506 through 41-2512, Idaho Code, shall prohibit, or be construed to prohibit, an insurer from requiring a provision for a reasonable deductible not exceeding two hundred fifty dollars ($250) in amount as to comprehensive coverage and not exceeding five hundred dollars ($500) in amount as to collision or physical damage coverages of the policy, as a condition to renewal of an automobile insurance policy.

History.
I.C., § 41-2511, as added by 1969, ch. 214, § 64, p. 625; am. 1991, ch. 312, § 1, p. 819; am. 2012, ch. 90, § 1, p. 253.

STATUTORY NOTES

Amendments.
The 2012 amendment, by ch. 90, substituted "two hundred fifty dollars ($250) in amount as to comprehensive coverage and not exceeding five hundred dollars ($500)" for "one hundred fifty dollars ($150) in amount as to comprehensive coverage and not exceeding three hundred dollars ($300)".

CHAPTER 27

TITLE INSURANCE

SECTION.
41-2705. Supervision — Policy forms — Premiums.
41-2706. Title insurance rates — Justification.

41-2705. Supervision — Policy forms — Premiums. — (1) The business of title insurance shall operate in Idaho under the control and supervision of the director of the department of insurance as to the premium rates for basic classifications of policy and underwriting contracts in relation thereto, escrow fee, rates, tract indexes and abstract records, and insurabil-

ity as provided in title 41, Idaho Code, and under such uniform rules and regulations as may be from time to time prescribed by the director of the department of insurance. No title insurer shall engage in the title insurance business with respect to any interest in Idaho property other than under the applicable laws of the state of Idaho and under such rules and regulations as may be issued by the director of the department of insurance. No policy of title insurance or guarantee of any character on Idaho property shall be issued unless written by a title insurer complying with all the provisions of the laws of the state of Idaho, holding a certificate of authority under chapter 3, title 41, Idaho Code, and under such rules and regulations as may be issued by the director of the department of insurance.

(2) The rates for the premiums for title insurance, the proportion of the premium for title insurance which is retained by a title insurance agent and the portion which is retained by a title insurer, shall be determined within the provisions of sections 41-2706, 41-2707 and 41-2708, Idaho Code, and the general provisions of title 41, Idaho Code; provided, not later than the effective date hereof each title insurer shall file its premium rates and basic policy classification in relation thereto, and the said rate so filed shall continue until changed as herein provided.

(3) The escrow fees of title insurers and title insurance agents shall be filed in accordance with rules promulgated by the director of the department of insurance.

(4) A title insurer shall file each form of certificate, policy, preliminary report, binder, guaranty or other underwriting contract of title insurance prior to the delivery or issuance thereof in Idaho. The filing of the form of policies and contracts of title insurance and the approval of the same shall be in accordance with sections 41-1812 and 41-1813, Idaho Code, as well as in conformance with chapter 27, title 41, Idaho Code.

(5) The provisions of sections 41-2705 through 41-2708, Idaho Code, shall not apply to a title insurer contracting as a reinsurer of a title insurance policy on Idaho property where no primary liability is assumed.

(6) The director of the department of insurance, for the purpose of carrying out this chapter shall have the right to require title insurers issuing policies in Idaho and title insurance agents to submit such information as needed as to expense of operations, loss experience, underwriting risks and other material matters.

(7) Any person aggrieved by any order, act or regulation of the director hereunder shall have the rights and remedies set forth in chapter 52, title 67, Idaho Code.

History.

I.C., § 41-2705, as added by 1973, ch. 135, § 2, p. 252; am. 2011, ch. 195, § 1, p. 556.

STATUTORY NOTES

Amendments.

The 2011 amendment, by ch. 195, added the subsection designations; in subsection (2), deleted "and the escrow fees of title insurers and title insurance agents" following "by a title insurer," deleted "and each title insurer and title insurance agent shall file its escrow fee, in effect on January 1, 1973" following "rela-

tion thereto," and deleted "and fee" following "the said rate"; and added subsection (3).

JUDICIAL DECISIONS

Class Actions.

In considering a borrower's Fed. R. Civ. P. 23 motion for class certification in an action alleging violation of this section and § 41-2707, the magistrate judge properly found that the borrower met the prerequisites for class certification; individual issues did not predominate because, although examining each class member's file was necessary, this was an almost automatic process to determine whether the title policy showed a prior mortgage and whether the person received the discounted rate for a refinanced residential mortgage. Lewis v. First Am. Title Ins. Co., 265 F.R.D. 536 (D. Idaho 2010).

41-2706. Title insurance rates — Justification. — Title insurance premium rates for the basic classification of policies and underwriting contracts shall be those filed by a title insurer or a title insurance rating organization with justification and approved by order of the director of the department of insurance, or, those filed by the director of the department of insurance with his justification therefor, hearing thereon and order of the director, both as more particularly hereinafter set forth. The division of the total premium between a title insurer and a title insurance agent shall be filed by the title insurer. The insurance premium rates on basic classification of policies and said division of total premium shall be deemed fixed by the director of the department of insurance upon the director's order approving the same (i) as filed and justified by a title insurer or title insurance rating organization, with or without hearing, or (ii) following a hearing on the same as filed and justified by the director of the department of insurance.

(1) Justification of title insurance rates proposed by a title insurer, a title insurance rating organization, or the director of the department of insurance shall be filed with any proposed change of rate, and the filing shall be justified by:

(a) the experience or judgment of the title insurer or title insurance rating organization or the director proposing the rates; or

(b) its interpretation of any statistical data relied upon; or

(c) the experience of other title insurers or title insurance rating organizations; or

(d) any other factors which the title insurer or rating organization or director deems relevant.

(2) Rates made hereunder shall not be excessive, nor inadequate for the safety and soundness of the title insurer and title insurance agent, and shall not be unfairly discriminatory, and shall be adopted giving due consideration to:

(a) desirability of stability of rate structures;

(b) necessity of assuring the financial solvency of a title insurer and title insurance agent in periods of economic depression by encouraging growth in assets of title insurers and title insurance agents in periods of high business and activity; and

(c) necessity for assuring a reasonable margin of underwriting profit sufficient to induce capital to be invested therein.

(3) Every title insurer and every title insurance rating organization shall adopt basic classifications of policies and contracts of title insurance which shall be used as the basis for rates. Rates for each classification may, at the discretion of the title insurer, or the title insurance rating organization filing the rate, be less than the cost of the expense elements in the case of smaller insurances, and the excess may be charged against larger insurances without rendering the rate unfairly discriminatory.

(4) When the director finds upon application by a title insurer that any rate for a particular kind or class of risk cannot practicably be filed before it is used, or any contract or kind of title insurance, by reason of rarity or peculiar circumstances, does not lend itself to advance determination and filing of rates, he may, under such rules and regulations as he may prescribe, permit such rate or contract or kind of title insurance to be used without a previous notice and thirty (30) day waiting period.

History.
I.C., § 41-2706, as added by 1973, ch. 135, § 3, p. 252; am. 2011, ch. 195, § 2, p. 556.

STATUTORY NOTES

Amendments.
The 2011 amendment, by ch. 195, in the first paragraph, deleted "and the escrow, closing or settlement fees shall be filed by the title insurer or agent as applicable and approved in the same manner as title insurance premiums" from the end of the second sentence and deleted "and said escrow fees" following "total premium" and "or title insurance agent" following "insurance rating organization" in the last sentence.

CHAPTER 33

INSURERS SUPERVISION, REHABILITATION AND LIQUIDATION

SECTION.

41-3345. Unclaimed and withheld funds. — (1) All unclaimed funds subject to distribution remaining in the liquidator's hands when he is ready to apply to the court for discharge, including the amount distributable to any creditor, shareholder, member, or other person who is unknown or cannot be found, shall be deposited with the state treasurer, and shall be paid without interest except in accordance with section 41-3342, Idaho Code, to the person entitled thereto or his legal representative upon proof satisfactory to the state treasurer of his right thereto. Any amount on deposit not claimed within six (6) years from discharge of the liquidator shall be deemed to have been abandoned and shall be escheated without formal escheat proceedings and be deposited with the state treasurer pursuant to chapter 5, title 14, Idaho Code.

(2) All funds withheld under section 41-3337, Idaho Code, and not distributed shall upon discharge of the liquidator be deposited with the state treasurer and paid by him in accordance with section 41-3342, Idaho Code.

Any sums remaining which under section 41-3342, Idaho Code, would revert to the undistributed assets of the insurer shall be transferred to the state treasurer and become the property of the state under subsection (1) hereof, unless the director in his discretion petitions the court to reopen the liquidation under section 41-3347, Idaho Code.

History.
I.C., § 41-3345, as added by 1981, ch. 249, § 2, p. 502; am. 2011, ch. 151, § 23, p. 414.

STATUTORY NOTES

Amendments.
The 2011 amendment, by ch. 151, substituted "state treasurer" for "tax collector" in the last sentence in subsection (1).

CHAPTER 43

IDAHO LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

SECTION.

41-4301. Short title. — This chapter shall be known and may be cited as the "Idaho Life and Health Insurance Guaranty Association Act."

History.
I.C., § 41-4301, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.
Former chapter 43 of Title 41, which comprised the following sections, were repealed by S.L. 2011, ch. 196, § 1, effective July 1 2011.

41-4301. Short title. [I.C., § 41-4301, as added by 1977, ch. 217, § 1, p. 636.]

41-4302. Purpose. [I.C., § 41-4302, as added by 1977, ch. 217, § 1, p. 636; am. 1987, ch. 292, § 1, p. 617; am. 2000, ch. 371, § 3, p. 1224.]

41-4303. Application of chapter. [I.C., § 41-4303, as added by 1977, ch. 217, § 1, p. 636; am. 1991, ch. 280, § 1, p. 723; am. 2000, ch. 323, § 1, p. 1090; am. 2000, ch. 371, § 4, p. 1224; am. 2005, ch. 108, § 1, p. 356; am. 2009, ch. 54, § 1, p. 150.]

41-4304. Construction. [I.C., § 41-4304, as added by 1977, ch. 217, § 1, p. 636.]

41-4305. Definitions. [I.C., § 41-4305, as added by 1977, ch. 217, § 1, p. 636; am. 1991, ch. 280, § 2, p. 723; am. 2009, ch. 54, § 2, p. 150.]

41-4306. Creation of the association. [I.C., § 41-4306, as added by 1977, ch. 217, § 1, p. 636.]

41-4307. Board of directors. [I.C., § 41-4307, as added by 1977, ch. 217, § 1, p. 636.]

41-4308. Powers and duties of the association. [I.C., § 41-4308, as added by 1977, ch. 217, § 1, p. 636; am. 1987, ch. 292, § 2, p. 617; am. 2000, ch. 323, § 2, p. 1090; am. 2000, ch. 371, § 5, p. 1224; am. 2009, ch. 54, § 3, p. 150.]

41-4309. Assessments. [I.C., § 41-4309, as added by 1977, ch. 217, § 1, p. 636; am. 1986, ch. 43, § 1, p. 127; am. 2000, ch. 371, § 6, p. 1224; am. 2005, ch. 108, § 2, p. 356.]

41-4310. Plan of operation. [I.C., § 41-4310, as added by 1977, ch. 217, § 1, p. 636.]

41-4311. Duties and powers of the director. [I.C., § 41-4311, as added by 1977, ch. 217, § 1, p. 636.]

41-4312. Prevention of insolvencies. [I.C., § 41-4312, as added by 1977, ch. 217, § 1, p. 636; am. 1987, ch. 292, § 3, p. 617; am. 1990, ch. 213, § 61, p. 480.]

41-4313. Credits for assessments paid. [I.C., § 41-4313, as added by 1977, ch. 217, § 1, p. 636; am. 1994, ch. 239, § 1, p. 751.]

41-4314. Miscellaneous provisions. [I.C., § 41-4314, as added by 1977, ch. 217, § 1, p. 636.]

41-4315. Examination of the association — Annual report. [I.C., § 41-4315, as added by 1977, ch. 217, § 1, p. 636.]

41-4316. Tax exemptions. [I.C., § 41-4316, as added by 1977, ch. 217, § 1, p. 636.]

41-4317. Immunity. [I.C., § 41-4317, as added by 1977, ch. 217, § 1, p. 636.]

41-4318. Stay of proceedings — Reopening default judgments. [I.C., § 41-4318, as added by 1977, ch. 217, § 1, p. 636.]

41-4319. Prohibited advertisement of insurance guaranty association act in sale of insurance. [I.C., § 41-4319, as added by 1977, ch. 217, § 1, p. 636; am. 2009, ch. 54, § 4, p. 150.]

41-4302. Purpose. — (1) The purpose of this chapter is to protect, subject to certain limitations, the persons specified in section 41-4303(1), Idaho Code, against failure in the performance of contractual obligations under life and health insurance policies and annuity contracts specified in section 41-4303(2), Idaho Code, because of the impairment or insolvency of the member insurer that issued the policies or contracts.

(2) To provide the protection stated in subsection (1) of this section, an association of insurers will pay benefits and continue coverages as provided for and limited by this chapter. Members of the association are subject to assessment to provide funds to carry out the purpose of this chapter.

History.
I.C., § 41-4302, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.
Former § 41-4302 was repealed. See Prior Laws, § 43-4301.

41-4303. Coverage and limitations. — (1) This chapter shall provide coverage for the policies and contracts specified in subsection (2) of this section:

(a) To persons, except for nonresident certificate holders under group policies or contracts who, regardless of where they reside, are the beneficiaries, assignees or payees of the persons covered under paragraph (b) of this subsection.

(b) To persons who are owners of or certificate holders under the policies or contracts, other than structured settlement annuities, and in each case who:

(i) Are residents; or

(ii) Are not residents, but only under all of the following conditions:

1. The insurer that issued the policies or contracts is domiciled in this state;

2. The states in which the persons reside have associations similar to the association created by this chapter; and

3. The persons are not eligible for coverage by an association in any other state due to the fact that the insurer was not licensed in the state at the time specified in the state's guaranty association law.

(c) For structured settlement annuities specified in subsection (2) of this section, paragraphs (a) and (b) of this subsection shall not apply, and this chapter shall, except as provided in paragraphs (d) and (e) of this subsection, provide coverage to a person who is a payee under a structured settlement annuity, or beneficiary of a payee if the payee is deceased, if the payee:

(i) Is a resident, regardless of where the contract owner resides; or

(ii) Is not a resident, but only under both of the following conditions:

1.(A) The contract owner of the structured settlement annuity is a resident; or

(B) The contract owner of the structured settlement annuity is not a resident; but the insurer that issued the structured settlement annuity is domiciled in this state; and the state in which the contract owner resides has an association similar to the association created in this chapter; and

2. Neither the payee or beneficiary nor the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides.

(d) The provisions of this chapter shall not provide coverage to a person who is a payee or beneficiary of a contract owner resident of this state, if the payee or beneficiary is afforded any coverage by the association of another state.

(e) This chapter is intended to provide coverage to a person who is a resident of this state and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this chapter is provided coverage under the laws of any other state, the person shall not be provided coverage under this chapter. In determining the application of the provisions of this paragraph in situations where a person could be covered by the association of more than one (1) state, whether as an owner, payee, beneficiary or assignee, the provisions of this chapter shall be construed in conjunction with other state laws to result in coverage by only one (1) association.

(2)(a) The provisions of this chapter shall provide coverage to the persons specified in subsection (1) of this section for direct, non-group life, health or annuity policies or contracts and for certificates under direct group policies and contracts and for supplemental contracts to any of these, except as limited by this chapter. Annuity contracts and certificates under group annuity contracts include allocated funding agreements, structured settlement annuities and any immediate or deferred annuity contracts.

(b) The provisions of this chapter shall not provide coverage for:

(i) A portion of a policy or contract not guaranteed by the insurer, or under which the risk is borne by the policy or contract owner;

(ii) A policy or contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract;

(iii) A portion of a policy or contract to the extent that the rate of interest on which it is based, or the interest rate, crediting rate or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value:

1. Averaged over the period of four (4) years prior to the date on which the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier, exceeds the rate of interest determined by subtracting two (2) percentage points from Moody's corporate bond yield average averaged for that same four (4) year period or for such lesser period if the policy or contract was issued less than four (4) years before the member insurer becomes an impaired or insolvent insurer under the provisions of this chapter, whichever is earlier; and

2. On and after the date on which the member insurer becomes an impaired or insolvent insurer under the provisions of this chapter, whichever is earlier, exceeds the rate of interest determined by subtracting three (3) percentage points from Moody's corporate bond yield average as most recently available;

(iv) A portion of a policy or contract issued to a plan or program of an employer, association or other person to provide life, health or annuity benefits to its employees, members or others, to the extent that the plan or program is self-funded or uninsured including, but not limited to, benefits payable by an employer, association or other person under:

1. A multiple employer welfare arrangement as defined in section 3(40) of the employee retirement income security act of 1974, 29 U.S.C. section 1002(40);

2. A minimum premium group insurance plan;

3. A stop-loss group insurance plan; or

4. An administrative services only contract;

(v) A portion of a policy or contract to the extent that it provides for:

1. Dividends or experience rating credits;

2. Voting rights; or

3. Payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;

(vi) A policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue the policy or contract in this state;

(vii) A portion of a policy or contract to the extent that the assessments required in section 41-4309, Idaho Code, with respect to the policy or contract are preempted by federal or state law;

(viii) An obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the contract owner or policy owner, including without limitation:

1. Claims based on marketing materials;

2. Claims based on side letters, riders or other documents that were issued by the insurer without meeting applicable policy form filing or approval requirements;

3. Misrepresentations of or regarding policy benefits;

4. Extra-contractual claims; or

5. A claim for penalties or consequential or incidental damages;

(ix) A contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer;

(x) An unallocated annuity contract;

(xi) A portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under the provisions of this chapter, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this subparagraph, the interest or change in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and will not be subject to forfeiture; and

(xii) A policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to 42 U.S.C. part C or 42 U.S.C. part D, commonly known as medicare parts C and D, or any regulations issued pursuant thereto.

(3) The benefits that the association may become obligated to cover shall in no event exceed the lesser of:

(a) The contractual obligations for which the insurer is liable or would have been liable if it were not an impaired or insolvent insurer; or

(b) Subject to the aggregate per life limitation in paragraph (c) of this subsection with respect to one (1) policy or contract:

(i) Three hundred thousand dollars ($300,000) in life insurance death benefits, but not more than one hundred thousand dollars ($100,000) in net cash surrender and net cash withdrawal values for life insurance;

(ii) Three hundred thousand dollars ($300,000) in health insurance claims or benefit payments or one hundred thousand dollars ($100,000) in net cash surrender and net cash withdrawal values for health benefits, except for major medical insurance as defined in section 41-4305, Idaho Code, and as provided for in subparagraph (iii) of this paragraph;

(iii) Five hundred thousand dollars ($500,000) for major medical insurance as defined in section 41-4305, Idaho Code;

(iv) Two hundred fifty thousand dollars ($250,000) in the present value

of annuity benefits, including net cash surrender and net cash withdrawal values;

(v) With respect to each payee of a structured settlement annuity, or beneficiary or beneficiaries of the payee if deceased, two hundred fifty thousand dollars ($250,000) in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values;

(c) However, in no event shall the association be obligated to cover more than:

(i) An aggregate of three hundred thousand dollars ($300,000) in benefits with respect to any one (1) life under paragraph (b) of this subsection, except with respect to benefits for major medical insurance as provided in paragraph (b)(iii) of this subsection, in which case the aggregate liability of the association shall not exceed five hundred thousand dollars ($500,000) with respect to any one (1) life; or

(ii) With respect to one (1) owner of multiple non-group policies of life insurance, whether the policy owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, more than five million dollars ($5,000,000) in benefits, regardless of the number of policies and contracts held by the owner; or

(d) The limitations set forth in this subsection are limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the association's obligations under the provisions of this chapter may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to its subrogation and assignment rights.

(4) In performing its obligations to provide coverage under section 41-4308, Idaho Code, the association shall not be required to guarantee, assume, reinsure or perform, or cause to be guaranteed, assumed, reinsured or performed, the contractual obligations of the insolvent or impaired insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract.

History.
I.C., § 41-4303, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.
Former § 41-4303 was repealed. See Prior Laws, § 43-4301.

Federal References.
Medicare parts C and D, referred to in paragraph (2)(b)(xii), are codified as 42 USCS § 1395w-21 et seq. and 42 USCS § 1395w-101, respectively.

Compiler's Notes.
For recent Moody's corporate average yields, see:
http://www.naic.org/research_moody.htm.
For Moody's Investors Service, Inc., see *http://www.moodys.com.*

41-4304. Construction. — The provisions of this chapter shall be construed to effect the purpose under section 41-4302, Idaho Code.

History.
I.C., § 41-4304, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.
Former § 41-4304 was repealed. See Prior Laws, § 43-4301.

41-4305. Definitions. — As used in this chapter:

(1) "Account" means any of the three (3) accounts maintained pursuant to section 41-4306, Idaho Code.

(2) "Association" means the Idaho life and health insurance guaranty association.

(3) "Authorized assessment" or "authorized," when used in the context of assessments, means a resolution by the board of directors has been passed whereby an assessment will be called immediately or in the future from member insurers for a specified amount. An assessment is authorized when the resolution is passed.

(4) "Benefit plan" means a specific employee, union or association of natural persons benefit plan.

(5) "Called assessment" or "called," when used in the context of assessments, means that a notice has been issued by the association to member insurers requiring that an authorized assessment be paid within the time frame set forth within the notice. An authorized assessment becomes a called assessment when notice is mailed by the association to member insurers.

(6) "Contractual obligation" means an obligation under a policy or contract or certificate under a group policy or contract, or portion thereof for which coverage is provided under section 41-4303, Idaho Code.

(7) "Covered policy" means a policy or contract or portion of a policy or contract for which coverage is provided under section 41-4303, Idaho Code.

(8) "Director" means the director of the Idaho department of insurance.

(9) "Extra-contractual claims" shall include, for example, claims relating to bad faith in the payment of claims, punitive or exemplary damages or attorney's fees and costs.

(10) "Impaired insurer" means a member insurer:

(a) Deemed by the director after the effective date of this chapter to be potentially unable to fulfill its contractual obligations and not an insolvent insurer; or

(b) Which, after the effective date of this chapter, is not an insolvent insurer and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(11) "Insolvent insurer" means a member insurer which, after the effective date of this chapter, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

(12)(a) "Major medical insurance" means, solely for purposes of this chapter, health insurance policies, contracts or certificates that are issued to provide hospital and medical-surgical coverage.

(b) "Major medical insurance" shall not include insurance policies, contracts or certificates:

(i) Issued by an insurer providing only accident-only, credit, dental, vision, long-term care or disability income insurance or specified disease or hospital confinement indemnity insurance; or

(ii) For medicare supplement insurance or for coverage supplemental to the coverage provided under the civilian health and medical program of the uniformed services (CHAMPUS).

(13)(a) "Member insurer" means an insurer licensed or that holds a certificate of authority to transact in this state any kind of insurance for which coverage is provided under section 41-4303, Idaho Code, and includes an insurer whose license or certificate of authority in this state may have been suspended, revoked, not renewed or voluntarily withdrawn.

(b) "Member insurer" does not include:

(i) A hospital or medical service corporation or organization, whether profit or nonprofit;

(ii) A fraternal benefit society;

(iii) A mandatory state pooling plan;

(iv) A mutual assessment company or other person that operates on an assessment basis;

(v) An insurance exchange;

(vi) An organization that issues charitable gift annuities under section 41-120, Idaho Code;

(vii) A mutual benefit association;

(viii) A reciprocal insurer;

(ix) A limited managed care plan; or

(x) A self-funded health care plan.

(14) "Moody's corporate bond yield average" means the monthly average corporates as published by Moody's investors service, inc., or any successor thereto.

(15) "Owner," "policy owner" or "contract owner" means the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the insurer. The terms owner, contract owner and policy owner do not include persons with a mere beneficial interest in a policy or contract.

(16) "Person" means an individual, corporation, limited liability company, partnership, association, governmental body or entity or voluntary organization.

(17)(a) "Premiums" means amounts or considerations, by whatever name called, received on covered policies or contracts less returned premiums, considerations and deposits and less dividends and experience credits.

(b) "Premiums" does not include amounts or considerations received for policies or contracts or for the portions of policies or contracts for which

coverage is not provided under section 41-4303(2), Idaho Code, except that assessable premium shall not be reduced on account of section 41-4303(2)(b)(iii), Idaho Code, relating to interest limitations and section 41-4303(3)(b), (c) and (d), Idaho Code, relating to limitations with respect to one (1) individual, one (1) participant and one (1) contract owner. "Premiums" shall not include:

(i) Premiums on an unallocated annuity contract; or

(ii) With respect to multiple non-group policies of life insurance owned by one (1) owner, whether the policy owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, premiums in excess of five million dollars ($5,000,000) with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner.

(18)(a) "Principal place of business" of a plan sponsor or a person other than a natural person means the single state in which the natural persons who establish policy for the direction, control and coordination of the operations of the entity as a whole primarily exercise that function, determined by the association in its reasonable judgment by considering the following factors:

(i) The state in which the primary executive and administrative headquarters of the entity is located;

(ii) The state in which the principal office of the chief executive officer of the entity is located;

(iii) The state in which the board of directors, or similar governing person or persons, of the entity conducts the majority of its meetings;

(iv) The state in which the executive or management committee of the board of directors, or similar governing person or persons, of the entity conducts the majority of its meetings;

(v) The state from which the management of the overall operations of the entity is directed; and

(vi) In the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the factors contained in subparagraphs (i) through (v) of this paragraph.

However, in the case of a plan sponsor, if more than fifty percent (50%) of the participants in the benefit plan are employed in a single state, that state shall be deemed to be the principal place of business of the plan sponsor.

(b) "Principal place of business" of a plan sponsor of a benefit plan shall be deemed to be the principal place of business of the association, committee, joint board of trustees or other similar group of representatives of the parties who establish or maintain the benefit plan that, in lieu of a specific or clear designation of a principal place of business, shall be deemed to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question.

(19) "Receivership court" means the court in the insolvent or impaired insurer's state having jurisdiction over the conservation, rehabilitation or liquidation of the insurer.

(20) "Resident" means a person to whom a contractual obligation is owed and who resides in this state on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an insolvent insurer. A person may be a resident of only one (1) state, which in the case of a person other than a natural person shall be its principal place of business. Citizens of the United States that are either (a) residents of foreign countries, or (b) residents of United States possessions, territories or protectorates that do not have an association similar to the association created in this chapter, shall be deemed residents of the state of domicile of the insurer that issued the policies or contracts.

(21) "State" means a state or a commonwealth of the United States, the District of Columbia, Puerto Rico, and a United States possession, territory or protectorate.

(22) "Structured settlement annuity" means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant.

(23) "Supplemental contract" means a written agreement entered into for the distribution of proceeds under a life, health or annuity policy or contract.

(24) "Unallocated annuity contract" means an annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under the contract or certificate.

History.
I.C., § 41-4305, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.
Former § 41-4305 was repealed. See Prior Laws, § 43-4301.

Federal References.
For civilian health and medical program for uniformed services (CHAMPUS), see 10 USCS § 1071.

Compiler's Notes.
The phrase "the effective date of this chapter" in paragraph (10)(a) refers to the effective date of S.L. 2011, ch. 196, which is July 1, 2011.

For recent Moody's corporate average yields, see:
http://www.naic.org/research_moody.htm.
For Moody's Investors Service, Inc., see *http://www.moodys.com.*

41-4306. Creation of the association. — (1) This chapter continues the existence of the nonprofit legal entity known as the Idaho life and health insurance guaranty association. All member insurers shall be and remain members of the association as a condition of their authority to transact insurance in this state. The association shall perform its functions under the plan of operation established and approved under section 41-4310, Idaho Code, and shall exercise its powers through a board of directors provided for

under section 41-4307, Idaho Code. For purposes of administration and assessment, the association shall continue the existence and maintenance of three (3) accounts:

(a) Life insurance account;

(b) Health insurance account, formerly designated the "disability insurance account"; and

(c) Annuity account.

(2) The association shall come under the immediate supervision of the director and shall be subject to the applicable provisions of the insurance laws of this state.

History.
I.C., § 41-4306, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.
Former § 41-4306 was repealed. See Prior Laws, § 43-4301.

41-4307. Board of directors. — (1) The board of directors of the association shall consist of not fewer than five (5) nor more than nine (9) member insurers serving terms as established in the plan of operation. The members of the board of directors shall be selected by member insurers subject to the approval of the director. Vacancies on the board of directors shall be filled for the remaining period of the term by a majority vote of the remaining board members subject to the approval of the director.

(2) In approving selections, the director shall consider, among other things, whether all member insurers are fairly represented.

(3) Members of the board of directors may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors, but members of the board of directors shall not otherwise be compensated by the association for their services.

History.
I.C., § 41-4307, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.
Former § 41-4307 was repealed. See Prior Laws, § 43-4301.

41-4308. Powers and duties of the association. — (1) If a member insurer is an impaired insurer, the association may, in its discretion, and subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer and that are approved by the director:

(a) Guarantee, assume or reinsure, or cause to be guaranteed, assumed,

or reinsured, any or all of the policies or contracts of the impaired insurer; and

(b) Provide such moneys, pledges, loans, notes, guarantees or other means as are proper to effectuate paragraph (a) of this subsection and assure payment of the contractual obligations of the impaired insurer pending action under paragraph (a) of this subsection.

(2) If a member insurer is an insolvent insurer, the association shall, in its discretion, either:

(a)(i)1. Guarantee, assume or reinsure, or cause to be guaranteed, assumed or reinsured, the policies or contracts of the insolvent insurer; or

2. Assure payment of the contractual obligations of the insolvent insurer; and

(ii) Provide moneys, pledges, loans, notes, guarantees, or other means reasonably necessary to discharge the association's duties; or

(b) Provide benefits and coverages in accordance with the following provisions:

(i) With respect to life and health insurance policies and annuities, assure payment of benefits for premiums identical to the premiums and benefits, except for terms of conversion and renewability, that would have been payable under the policies or contracts of the insolvent insurer, for claims incurred:

1. With respect to group policies and contracts, not later than the earlier of the next renewal date under those policies or contracts or forty-five (45) days, but in no event less than thirty (30) days, after the date on which the association becomes obligated with respect to the policies and contracts;

2. With respect to non-group policies, contracts, and annuities not later than the earlier of the next renewal date, if any, under the policies or contracts or one (1) year, but in no event less than thirty (30) days, from the date on which the association becomes obligated with respect to the policies or contracts;

(ii) Make diligent efforts to provide all known insureds or annuitants, for non-group policies and contracts, or group policy owners with respect to group policies and contracts, thirty (30) days' notice of the termination, pursuant to subparagraph (i) of this paragraph, of the benefits provided;

(iii) With respect to non-group life and health insurance policies and annuities covered by the association, make available to each known insured or annuitant, or owner if other than the insured or annuitant, and with respect to an individual formerly insured or formerly an annuitant under a group policy who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of subparagraph (iv) of this paragraph, if the insureds or annuitants had a right under law or the terminated policy or annuity to convert coverage to individual coverage or to continue an individual policy or annuity in force until a specified age or for a specified time, during which the insurer had no right

unilaterally to make changes in any provision of the policy or annuity or had a right only to make changes in premium by class:

(iv)1. In providing the substitute coverage required under subparagraph (iii) of this paragraph, the association may offer either to reissue the terminated coverage or to issue an alternative policy;

2. Alternative or reissued policies shall be offered without requiring evidence of insurability, and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy; and

3. The association may reinsure any alternative or reissued policy;

(v)1. Alternative policies adopted by the association shall be subject to the approval of the domiciliary insurance director. The association may adopt alternative policies of various types for future issuance without regard to any particular impairment or insolvency;

2. Alternative policies shall contain at least the minimum statutory provisions required in this state and provide benefits that shall not be unreasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates that it shall adopt. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured, but shall not reflect any changes in the health of the insured after the original policy was last underwritten; and

3. Any alternative policy issued by the association shall provide coverage of a type similar to that of the policy issued by the impaired or insolvent insurer, as determined by the association;

(vi) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy, the premium shall be set by the association in accordance with the amount of insurance provided and the age and class of risk, subject to approval of the domiciliary insurance director;

(vii) The association's obligations with respect to coverage under any policy of the impaired or insolvent insurer or under any reissued or alternative policy shall cease on the date the coverage or policy is replaced by another similar policy by the policy owner, the insured or the association; and

(viii) When proceeding under this paragraph (b) of this subsection with respect to a policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with section 41-4303(2)(b)(iii), Idaho Code.

(3) Nonpayment of premiums within thirty-one (31) days after the date required under the terms of any guaranteed, assumed, alternative or reissued policy or contract or substitute coverage shall terminate the association's obligations under the policy or coverage under this chapter with respect to the policy or coverage, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of this chapter.

(4) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the

association. If the liquidator of an insolvent insurer requests, the association shall provide a report to the liquidator regarding such premium collected by the association. The association shall be liable for unearned premiums due to policy or contract owners arising after the entry of the order.

(5) The protection provided by this chapter shall not apply where any guarantee protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state.

(6) In carrying out its duties under subsection (2) of this section, the association may:

(a) Subject to approval by a court in this state, impose permanent policy or contract liens in connection with a guarantee, assumption or reinsurance agreement, if the association finds that the amounts which can be assessed under this chapter are less than the amounts needed to assure full and prompt performance of the association's duties under this chapter, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of such permanent policy or contract liens, to be in the public interest; or

(b) Subject to approval by a court in this state, impose temporary moratoriums or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value. In addition, in the event of a temporary moratorium or moratorium charge imposed by the receivership court on payment of cash values or policy loans, or on any other right to withdraw funds held in conjunction with policies or contracts, out of the assets of the impaired or insolvent insurer, the association may defer the payment of cash values, policy loans or other rights by the association for the period of the moratorium or moratorium charge imposed by the receivership court, except for claims covered by the association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

(7) A deposit in this state, held pursuant to law or required by the director for the benefit of creditors, including policy owners, not turned over to the domiciliary liquidator upon the entry of a final order of liquidation or order approving a rehabilitation plan of an insurer domiciled in this state or in a reciprocal state, pursuant to chapter 8, title 41, Idaho Code, shall be promptly paid to the association. The association shall be entitled to retain a portion of any amount so paid to it equal to the percentage determined by dividing the aggregate amount of policy owners' claims related to that insolvency for which the association has provided statutory benefits by the aggregate amount of all policy owners' claims in this state related to that insolvency and shall remit to the domiciliary receiver the amount so paid to the association less the amount retained pursuant to this subsection. Any amount so paid to the association and retained by it shall be treated as a distribution of state assets pursuant to applicable state receivership law dealing with early access disbursements.

(8) If the association fails to act within a reasonable period of time with respect to an insolvent insurer, as provided in subsection (2) of this section, the director shall have the powers and duties of the association under this chapter with respect to the insolvent insurer.

(9) The association may render assistance and advice to the director, upon the director's request, concerning rehabilitation, payment of claims, continuance of coverage or the performance of other contractual obligations of an impaired or insolvent insurer.

(10) The association shall have standing to appear or intervene before a court or agency in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this chapter or with jurisdiction over any person or property against which the association may have rights through subrogation or otherwise. Standing shall extend to all matters germane to the powers and duties of the association including, but not limited to, proposals for reinsuring, modifying or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The association shall also have the right to appear or intervene before a court or agency in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or with jurisdiction over any person or property against whom the association may have rights through subrogation or otherwise.

(11)(a) A person receiving benefits under this chapter shall be deemed to have assigned the rights under, and any causes of action against any person for losses arising under, resulting from or otherwise relating to the covered policy or contract to the association to the extent of the benefits received because of this chapter, whether the benefits are payments of, or on account of, contractual obligations, continuation of coverage or provision of substitute or alternative coverages. The association may require a written instrument of assignment to it of such rights and cause of action by any payee, policy or contract owner, beneficiary, insured or annuitant as a condition precedent to the receipt of any right or benefits conferred by this chapter upon the person.

(b) The subrogation rights of the association under this subsection shall have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under this chapter.

(c) In addition to paragraphs (a) and (b) of this subsection, the association shall have all common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or owner, beneficiary or payee of a policy or contract with respect to the policy or contract, including without limitation, in the case of a structured settlement annuity, any rights of the owner, beneficiary or payee of the annuity, to the extent of benefits received pursuant to this chapter, against a person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment therefor, excepting any such person responsible solely by reason of serving as an assignee in respect of a qualified assignment under Internal Revenue Code, section 130.

(d) If the preceding provisions of this subsection are invalid or ineffective with respect to any person or claim for any reason, the amount payable by the association with respect to the related covered obligations shall be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies, or portion thereof, covered by the association.

(e) If the association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the association has rights as described in paragraphs (a) through (d) of this subsection, the person shall pay to the association the portion of the recovery attributable to the policies, or portion thereof, covered by the association.

(12) In addition to the rights and powers elsewhere in this chapter, the association may:

(a) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this chapter;

(b) Sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments under section 41-4309, Idaho Code, and to settle claims or potential claims against it;

(c) Borrow money to effect the purposes of this chapter; any notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic insurers and may be carried as admitted assets;

(d) Employ or retain such persons as are necessary or appropriate to handle the financial transactions of the association, and to perform such other functions as become necessary or proper under this chapter;

(e) Take such legal action as may be necessary or appropriate to avoid or recover payment of improper claims;

(f) Exercise, for the purposes of this chapter and to the extent approved by the director, the powers of a domestic life or health insurer, but in no case may the association issue insurance policies or annuity contracts other than those issued to perform its obligations under this chapter;

(g) Reorganize itself with the prior written approval of the director from a nonprofit association into a corporation or other legal form of nonprofit entity permitted by the laws of the state of Idaho;

(h) Request information from a person seeking coverage from the association in order to aid the association in determining its obligations under this chapter with respect to the person, and the person shall promptly comply with the request; and

(i) Take other necessary or appropriate action to discharge its duties and obligations under this chapter or to exercise its powers under this chapter.

(13) The association may join an organization of one (1) or more other state associations of similar purposes, to further the purposes and administer the powers and duties of the association.

(14) With respect to covered policies for which the association becomes obligated after an entry of an order of liquidation, the association may elect to succeed to the rights of the insolvent insurer arising after the order of liquidation under any contract of reinsurance to which the insolvent insurer was a party, to the extent that such contract provides coverage for losses occurring after the date of the order of liquidation. As a condition to making

this election, the association must pay all unpaid premiums due under the contract for coverage relating to periods before and after the date of the order of liquidation.

(15) The board of directors of the association shall have discretion and may exercise reasonable business judgment to determine the means by which the association is to provide the benefits of this chapter in an economical and efficient manner.

(16) Where the association has arranged or offered to provide the benefits of this chapter to a covered person under a plan or arrangement that fulfills the association's obligations under this chapter, the person shall not be entitled to benefits from the association in addition to or other than those provided under the plan or arrangement.

(17) Venue in a suit against the association arising under this chapter shall be in Ada county. The association shall not be required to give an appeal bond in an appeal that relates to a cause of action arising under the provisions of this chapter.

(18) In carrying out its duties in connection with guaranteeing, assuming or reinsuring policies or contracts under subsection (1) or (2) of this section, the association may, subject to approval of the receivership court, issue substitute coverage for a policy or contract that provides an interest rate, crediting rate or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract in accordance with the following provisions:

(a) In lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for:

(i) A fixed interest rate;

(ii) Payment of dividends with minimum guarantees; or

(iii) A different method for calculating interest or changes in value;

(b) There is no requirement for evidence of insurability, waiting period or other exclusion that would not have applied under the replaced policy or contract; and

(c) The alternative policy or contract is substantially similar to the replaced policy or contract in all other material terms.

History.

I.C., § 41-4308, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.

Former § 41-4308 was repealed. See Prior Laws, § 43-4301.

Federal References.

Internal Revenue Code, section 130, referred to in paragraph (11)(c), is codified as 26 USCS § 130.

41-4309. Assessments. — (1) For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers, separately for each account, at

such time and for such amounts as the board of directors finds necessary. Assessments shall be due not less than thirty (30) days after prior written notice to the member insurers and shall accrue interest at eight percent (8%) per annum on and after the due date.

(2) There shall be two (2) classes of assessments:

(a) Class A assessments shall be authorized and called for the purpose of meeting administrative and other expenses. Class A assessments may be authorized and called whether or not related to a particular impaired or insolvent insurer.

(b) Class B assessments shall be authorized and called to the extent necessary to carry out the powers and duties of the association under section 41-4308, Idaho Code, with regard to an impaired or an insolvent insurer.

(3)(a) The amount of a class A assessment shall be determined by the board of directors and may be authorized and called on a pro rata or non-pro rata basis. If pro rata, the board of directors may provide that it be credited against future class B assessments. The total of all non-pro rata assessments shall not exceed three hundred dollars ($300) per member insurer in any one (1) calendar year. The amount of a class B assessment shall be allocated for assessment purposes among the accounts pursuant to an allocation formula, which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board of directors in its sole discretion as being fair and reasonable under the circumstances.

(b) Class B assessments against member insurers for each account shall be in the proportion that the premiums received on business in this state by each assessed member insurer on policies covered by each account for the calendar year preceding the assessments bears to such premiums received on business in this state for the calendar year preceding the assessment by all assessed member insurers.

(c) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer shall not be authorized or called until necessary to implement the purposes of this chapter. Classification of assessments under this subsection and subsection (2) of this section and computation of assessments under this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. The association shall notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called within one hundred eighty (180) days after the assessment is authorized.

(4) The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board of directors, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated, or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. Once the conditions that caused a

deferral have been removed or rectified, the member insurer shall pay all assessments that were deferred pursuant to a repayment plan approved by the association.

(5)(a) The total of all class B assessments authorized by the association with respect to a member insurer for each account shall not in one (1) calendar year exceed two percent (2%) of such insurer's premiums received in this state during the calendar year preceding the assessment on the policies covered by the account. If the maximum assessment, together with the other assets of the association in an account, does not provide in any one (1) year in an account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed as soon thereafter as permitted by this chapter.

(b) The board of directors may provide in the plan of operation a method of allocating funds among claims, whether relating to one (1) or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

(6) The board of directors may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each insurer to that account, the amount by which the assets of the account exceed the amount the board of directors finds is necessary to carry out during the coming year the obligations of the association with regard to that account, including assets accruing from assignment, subrogation, net realized gains and income from investments.

A reasonable amount, as determined by the board of directors in its discretion, may be retained by the association in any account to provide funds for the continuing and future expenses of the association and for future loss claims.

(7) It shall be proper for any member insurer, in determining its premium rates and policy owner dividends as to any kind of insurance within the scope of this chapter, to consider the amount reasonably necessary to meet its assessment obligations under this chapter.

(8) The association shall issue to each insurer paying an assessment under this chapter, other than a class A assessment, a certificate of contribution in a form prescribed by the director for the amount of the assessment so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the director may approve.

(9)(a) A member insurer that wishes to protest all or part of an assessment shall pay when due the full amount of the assessment as set forth in the notice provided by the association. The payment shall be available to meet association obligations during the pendency of the protest or any subsequent appeal. Payment shall be accompanied by a statement in writing that the payment is made under protest and setting forth a brief statement of the grounds for the protest.

(b) Within sixty (60) days following the payment of an assessment under protest by a member insurer, the association shall notify the member

insurer in writing of its determination with respect to the protest unless the association notifies the member insurer that additional time is required to resolve the issues raised by the protest.

(c) Within thirty (30) days after a final decision has been made, the association shall notify the protesting member insurer in writing of that final decision. Within sixty (60) days of receipt of notice of the final decision, the protesting member insurer may appeal that final action to the director.

(d) In the alternative to rendering a final decision with respect to a protest based on a question regarding the assessment base, the association may refer protests to the director for a final decision, with or without a recommendation from the association.

(e) If the protest or appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member insurer.

(10) The association may request information of member insurers in order to aid in the exercise of its power under this section, and member insurers shall promptly comply with the request.

History.
I.C., § 41-4309, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.
Former § 41-4309 was repealed. See Prior Laws, § 43-4301.

41-4310. Plan of operation. — (1) The association shall submit to the director a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the association. The plan of operation and any amendments thereto shall become effective upon the director's written approval or unless it has not been disapproved within thirty (30) days.

(2) All member insurers shall comply with the plan of operation.

(3) The plan of operation shall, in addition to requirements enumerated elsewhere in this chapter:

(a) Establish procedures for handling the assets of the association;

(b) Establish the amount and method of reimbursing members of the board of directors under section 41-4307, Idaho Code;

(c) Establish regular places and times for meetings including telephone conference calls of the board of directors;

(d) Establish procedures for records to be kept of all financial transactions of the association, its agents and the board of directors;

(e) Establish the procedures whereby selections for the board of directors will be made and submitted to the director;

(f) Establish any additional procedures for assessments under section 41-4309, Idaho Code; and

(g) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

(4) The plan of operation may provide that any or all powers and duties of the association, except those under section 41-4308(12)(c), Idaho Code, and section 41-4309, Idaho Code, are delegated to a corporation, association or other organization which performs or will perform functions similar to those of this association, or its equivalent, in two (2) or more states. Such a corporation, association or organization shall be reimbursed for any payments made on behalf of the association and shall be paid for its performance of any function of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the director, and may be made only to a corporation, association or organization which extends protection not substantially less favorable and effective than that provided by this chapter.

History.
I.C., § 41-4310, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.
Former § 41-4310 was repealed. See Prior Laws, § 43-4301.

41-4311. Duties and powers of the director. — In addition to the duties and powers enumerated elsewhere in this chapter:

(1) The director shall:

(a) Upon request of the board of directors, provide the association with a statement of the premiums in this and any other appropriate states for each member insurer; and

(b) When an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time. Notice to the impaired insurer shall constitute notice to its shareholders, if any. The failure of the insurer to promptly comply with such demand shall not excuse the association from the performance of its powers and duties under this chapter.

(2) The director may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer that fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the director may levy a forfeiture on any member insurer that fails to pay an assessment when due. The forfeiture shall not exceed five percent (5%) of the unpaid assessment per month, but no forfeiture shall be less than one hundred dollars ($100) per month.

(3) A final action of the board of directors or the association may be appealed to the director by a member insurer if the appeal is taken within sixty (60) days of its receipt of notice of the final action being appealed. A final action or order of the director shall be subject to judicial review in a court of competent jurisdiction in accordance with the laws of this state that apply to the actions or orders of the director.

(4) The liquidator, rehabilitator or conservator of an impaired or insolvent insurer may notify all interested persons of the effect of this chapter.

History.
I.C., § 41-4311, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.
Former § 41-4311 was repealed. See Prior Laws, § 43-4301.

41-4312. Prevention of insolvencies. — (1) To aid in the detection and prevention of insurer insolvencies or impairments, it shall be the duty of the director to:

(a) Notify the insurance directors or commissioners of all the other states, territories of the United States and the District of Columbia within thirty (30) days following the action taken or the date the action occurs, when the director takes any of the following actions against a member insurer:

(i) Revokes a license;

(ii) Suspends a license; or

(iii) Makes a formal order that the company restrict its premium writing, obtain additional contributions to surplus, withdraw from the state, reinsure all or any part of its business, or increase capital, surplus, or any other account for the security of policy owners or creditors.

(b) Report to the board of directors when the director has taken any of the actions set forth in paragraph (a) of this subsection or has received a report from any other director indicating that any such action has been taken in another state. The report to the board of directors shall contain all significant details of the action taken or the report received from another director.

(c) Report to the board of directors when the director has reasonable cause to believe from an examination, whether completed or in process, of any member insurer that the insurer may be an impaired or insolvent insurer.

(d) Furnish to the board of directors the national association of insurance commissioners (NAIC) insurance regulatory information system (IRIS) ratios and listings of companies not included in the ratios developed by the NAIC, and the board of directors may use the information contained therein in carrying out its duties and responsibilities under this section. The report and the information contained therein shall be kept confidential by the board of directors until such time as made public by the director or other lawful authority.

(2) The director may seek the advice and recommendations of the board of directors concerning any matter affecting the duties and responsibilities of the director regarding the financial condition of member insurers and companies seeking admission to transact insurance business in this state.

(3) The board of directors may, upon majority vote, make reports and recommendations to the director upon any matter germane to the solvency,

liquidation, rehabilitation or conservation of any member insurer or germane to the solvency of any company seeking to do an insurance business in this state. The reports and recommendations shall not be considered public documents.

(4) The board of directors may, upon majority vote, notify the director of any information indicating a member insurer may be an impaired or insolvent insurer.

(5) The board of directors may, upon majority vote, make recommendations to the director for the detection and prevention of insurer insolvencies.

History.
I.C., § 41-4312, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.
Former § 41-4312 was repealed. See Prior Laws, § 43-4301.

Compiler's Notes.
The letters "NAIC" enclosed in parentheses so appeared in the law as enacted.

41-4313. Credits for assessments paid. — (1) A member insurer may offset against its premium tax liability to this state an assessment described in section 41-4309(8), Idaho Code, to the extent of twenty percent (20%) of the amount of the assessment for each of the five (5) calendar years following the year in which the assessment was paid. An allowable offset, or portion thereof, not used in any calendar year cannot be carried over or back to any other year.

(2) Any sums acquired by refund, pursuant to section 41-4309(6), Idaho Code, from the association which have theretofore been written off by contributing insurers and offset against premium taxes as provided in subsection (1) of this section, and are not then needed for purposes of this chapter, shall be paid by the association to the director and by him deposited with the state treasurer for credit to the general account of the state operating fund.

(3) Any sums acquired by refund, pursuant to section 41-4309(6), Idaho Code, from the association which have theretofore been written off by contributing insurers and offset against premium taxes as provided in subsection (1) of this section, and are not then needed for purposes of this chapter, shall be paid by the association to the director and by him deposited with the state treasurer for credit to the general account of the state operating fund.

History.
I.C., § 41-4313, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.
Former § 41-4313 was repealed. See Prior Laws, § 43-4301.

41-4314. Miscellaneous provisions. — (1) This chapter shall not be construed to reduce the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability.

(2) Records shall be kept of all meetings of the board of directors to discuss the activities of the association in carrying out its powers and duties under section 41-4308, Idaho Code. The records of the association with respect to an impaired or insolvent insurer shall not be disclosed prior to the termination of a liquidation, rehabilitation or conservation proceeding involving the impaired or insolvent insurer, except upon the:

(a) Termination of the impairment or insolvency of the insurer; or

(b) Order of a court of competent jurisdiction.

Nothing in this subsection shall limit the duty of the association to render a report of its activities under section 41-4315, Idaho Code.

(3) For the purpose of carrying out its obligations under this chapter, the association shall be deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the association is entitled as subrogee pursuant to section 41-4308(11), Idaho Code. Assets of the impaired or insolvent insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by this chapter. Assets attributable to covered policies, as used in this subsection, are that proportion of the assets which the reserves that should have been established for such policies bear to the reserves that should have been established for all policies of insurance written by the impaired or insolvent insurer.

(4) As a creditor of the impaired or insolvent insurer, as established in subsection (3) of this section and consistent with section 41-3334, Idaho Code, the association and other similar associations shall be entitled to receive a disbursement of assets out of the marshaled assets, from time to time as the assets become available to reimburse it, as a credit against contractual obligations under this chapter. If the liquidator has not, within one hundred twenty (120) days of a final determination of insolvency of an insurer by the receivership court, made an application to the court for the approval of a proposal to disburse assets out of marshaled assets to guaranty associations having obligations because of the insolvency, then the association shall be entitled to make application to the receivership court for approval of its own proposal to disburse these assets.

(5)(a) Prior to the termination of any liquidation, rehabilitation or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the association, the shareholders and policy owners of the insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of the insolvent insurer. In such a determination, consideration shall be given to the welfare of the policy owners of the continuing or successor insurer.

(b) No distribution to stockholders, if any, of an impaired or insolvent insurer shall be made until and unless the total amount of valid claims of

the association with interest thereon for funds expended in carrying out its powers and duties under section 41-4308, Idaho Code, with respect to the insurer have been fully recovered by the association.

(6)(a) If an order for liquidation or rehabilitation of an insurer domiciled in this state has been entered, the receiver appointed under the order shall have a right to recover on behalf of the insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the insurer on its capital stock, made at any time during the five (5) years preceding the petition for liquidation or rehabilitation subject to the limitations of paragraphs (b), (c) and (d) of this subsection.

(b) No such distribution shall be recoverable if the insurer shows that when paid the distribution was lawful and reasonable, and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

(c) Any person who was an affiliate that controlled the insurer at the time the distributions were paid shall be liable up to the amount of distributions received. Any person who was an affiliate that controlled the insurer at the time the distributions were declared shall be liable up to the amount of distributions which would have been received if they had been paid immediately. If two (2) or more persons are liable with respect to the same distributions, they shall be jointly and severally liable.

(d) The maximum amount recoverable under this subsection shall be the amount needed in excess of all other available assets of the insolvent insurer to pay the contractual obligations of the insolvent insurer.

(e) If any person liable under paragraph (c) of this subsection is insolvent, all its affiliates that controlled it at the time the distribution was paid shall be jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

History.
I.C., § 41-4314, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.
Former § 41-4314 was repealed. See Prior Laws, § 43-4301.

41-4315. Examination of the association — Annual report. — The association shall be subject to examination and regulation by the director. The board of directors shall submit to the director each year, not later than May 1 of each year, a financial report in a form approved by the director and a report of its activities during the preceding fiscal year. Upon the request of a member insurer, the association shall provide the member insurer with a copy of the report.

History.
I.C., § 41-4315, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.
Former § 41-4315 was repealed. See Prior Laws, § 43-4301.

41-4316. Tax exemptions. — The association shall be exempt from payment of all fees and all taxes levied by this state or any of its subdivisions, except taxes levied on real property.

History.
I.C., § 41-4316, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.
Former § 41-4316 was repealed. See Prior Laws, § 43-4301.

41-4317. Immunity. — There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer or its agents or employees, the association or its agents or employees, members of the board of directors or the director or the director's representatives, for any action or omission by them in the performance of their powers and duties under this chapter. This immunity shall extend to the participation in any organization of one (1) or more other state associations of similar purposes and to any such organization and its agents or employees.

History.
I.C., § 41-4317, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.
Former § 41-4317 was repealed. See Prior Laws, § 43-4301.

41-4318. Stay of proceedings — Reopening default judgments. — All proceedings in which the insolvent insurer is a party in any court in this state shall be stayed one hundred eighty (180) days from the date an order of liquidation, rehabilitation or conservation is final to permit proper legal action by the association on any matters germane to its powers or duties. As to judgment under any decision, order, verdict or finding based on default, the association may apply to have such judgment set aside by the same court that made such judgment and shall be permitted to defend against such suit on the merits.

History.
I.C., § 41-4318, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.
Former § 41-4318 was repealed. See Prior Laws, § 43-4301.

41-4319. Prohibited advertisement of insurance guaranty association act in commercial sales. — No person, including an insurer, agent or affiliate of an insurer shall make, publish, disseminate, circulate or place before the public, or cause directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in any newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio station or television station, or in any other way, any advertisement, announcement or statement, written or oral, which uses the existence of the insurance guaranty association of this state for the purpose of sales, solicitation or inducement to purchase any form of insurance covered by the Idaho life and health insurance guaranty association act. Provided however, that this section shall not apply to the Idaho life and health insurance guaranty association or any other entity which does not sell or solicit insurance. This section shall also not prohibit the furnishing of written information that is in a form prepared by the association and approved by the director upon request of the policy owner.

History.
I.C., § 41-4319, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.
Former § 41-4319 was repealed. See Prior Laws, § 43-4301.

41-4320. Application. — This chapter shall apply to coverage the guaranty association provides in connection with any member insurer that was first placed under an order of liquidation on or after January 1, 2011.

History.
I.C., § 41-4320, as added by 2011, ch. 196, § 2, p. 558.

CHAPTER 49

PETROLEUM CLEAN WATER TRUST FUND ACT

SECTION.

41-4903. Definitions. — For the purposes of this chapter:

(1) "Aboveground storage tank" means any one (1) or a combination of tanks, including pipes connected thereto, that is used to contain an accumulation of petroleum or petroleum products, and the volume of which, including the volume of pipes connected thereto, is less than ten percent

(10%) beneath the surface of the ground. This term does not include a heating tank, farm tank or residential tank or any tank with a capacity of one hundred ten (110) gallons or less.

(2) "Accidental release" means any sudden or nonsudden release of petroleum from a storage tank that results in a need for corrective action or compensation for bodily injury or property damage neither expected nor intended by the tank owner or operator.

(3) "Administrator" means the state insurance fund or any person employed by the board of trustees to replace the state insurance fund, employed by the board to administer the Idaho petroleum clean water trust fund.

(4) "Application fee" means the amount paid or payable by an owner or operator applying for a contract of insurance with the trust fund to offset the costs of issuing contracts of insurance and other costs of administering this fund.

(5) "Board" means the board of trustees appointed by the governor.

(6) "Bodily injury" means any bodily injury, sickness, disease or death sustained by any person and caused by an occurrence defined in subsection (19) of this section.

(7) "Contamination" means the presence of petroleum or petroleum products in surface or subsurface soil, surface water, or ground water.

(8) "Commission" means the state tax commission of the state of Idaho.

(9) "Corrective action" means those actions as are reasonably necessary to satisfy applicable federal and state standards in the event of a release into the environment from a petroleum storage tank. Corrective action includes initial corrective action response or actions consistent with a remedial action to clean up contaminated soil and ground water or address residual effects after initial corrective action is taken, as well as actions necessary to monitor, assess and evaluate a release. Corrective action also includes the cost of removing a tank which is releasing or has been releasing petroleum products and the release cannot be corrected without removing the tank; but corrective action does not include the cost of replacing this tank with another tank.

(10) "Department" means the department of insurance of the state of Idaho.

(11) "Director" means the director of the department of insurance.

(12) "Farm tank" means any tank with a capacity of more than one hundred ten (110) gallons but less than one thousand one hundred (1,100) gallons situated above ground or underground which is used for storing motor fuel for noncommercial purposes and which is located on a tract of land devoted to the production of crops or raising animals, including fish, and associated residences and improvements. A farm tank must be located on the farm property. "Farm" includes fish hatcheries, rangeland and nurseries with growing operations.

(13) "Free product" means petroleum or petroleum products in the nonaqueous phase, (e.g., liquid not dissolved in water).

(14) "Fund" or "trust fund" means the Idaho petroleum clean water trust fund.

(15) "Heating tank" means any tank with a capacity of more than one hundred ten (110) gallons situated above ground or underground which is used for storing heating oil for consumptive use on the premises where stored.

(16) "Legal defense costs" means any expense that an owner or operator or the trust fund incurs in defending against claims or actions brought by the federal environmental protection agency or a state agency to require corrective action or to recover the costs of corrective action; or by or on behalf of a third party for bodily injury or property damage caused by a release.

(17) "Licensed distributor" means any distributor who has obtained a license under the provisions of section 63-2427A, Idaho Code. If a person subject to the fee imposed by section 41-4909(7), Idaho Code, is not required to obtain a distributor's license under paragraph (a) or (b) of subsection (1) of section 63-2427A, Idaho Code, such person shall apply to the commission for a limited license for the purpose of complying with the requirements of this chapter. Such a limited license shall not be valid for any other purpose. No bond shall be required for a limited license. A holder of a limited license is a "licensed distributor" for the purposes of filing reports, paying fees and other actions necessary to the proper administration and enforcement of this chapter.

(18) "Noncommercial purposes" means not for resale, with respect to motor fuels.

(19) "Occurrence" means an accident, including continuous or repeated exposure to conditions, which resulted in a release into the environment of petroleum products from a petroleum storage tank.

(20) "Operator" means any person in control, or having responsibility for, the daily operations of a petroleum storage tank.

(21) "Owner" means the owner of a petroleum storage tank, except that "owner" does not include any person who, without participation in the management of a petroleum storage tank, holds indicia of ownership primarily to protect the owner's security interest in the tank.

(22) "Person" means any corporation, association, partnership, one (1) or more individuals, or any governmental unit, or agency thereof, other than federal or state agencies.

(23) "Petroleum" and/or "petroleum products" mean crude oil, or any fraction thereof, which is liquid at standard conditions of temperature and pressure (i.e., at sixty (60) degrees fahrenheit and fourteen and seven-tenths (14.7) pounds per square inch absolute). The term includes motor gasoline, gasohol, other alcohol blended fuels, diesel fuel, heating oil and aviation fuel. Biodiesel and biodiesel blends, as those terms are defined in section 63-2401, Idaho Code, ethanol, and natural gasoline are also petroleum or petroleum products.

(24) "Property damage" means injury or destruction to tangible property caused by an occurrence.

(25) "Release" means any spilling, leaking, emitting, discharging, escaping, leaching, or disposing from a petroleum storage tank into ground water, surface water, or surface or subsurface soils.

(26) "Residential tank" means any tank with a capacity of more than one hundred ten (110) gallons but less than one thousand one hundred (1,100)

gallons situated above ground or underground which is used for storing motor fuel for noncommercial purposes and which is located on property used primarily for dwelling purposes.

(27) "Site" means a single parcel of property where petroleum or petroleum products are stored in a petroleum storage tank and includes all contiguous land, structures, other appurtenances, surface water, ground water, surface and subsurface soil, and subsurface strata within and beneath the property boundary.

(28) "State" means the state of Idaho or any office, department, agency, authority, commission, board, institution, hospital, college, university or other instrumentality thereof.

(29) "Tank" means a stationary device designed to contain an accumulation of petroleum or petroleum products and constructed of nonearthen materials (e.g., concrete, steel, plastic) that provide structural support.

(30) "Trustees" means the trustees of the Idaho petroleum clean water trust fund, who are appointed by the governor pursuant to this chapter.

(31) "Underground storage tank" means any one (1) or combination of tanks, including underground pipes connected thereto, that is used to contain an accumulation of petroleum or petroleum products, and the volume of which, including the volume of underground pipes connected thereto, is ten percent (10%) or more beneath the surface of the ground. This term does not include any:

(a) Farm or residential tank of one thousand one hundred (1,100) gallons or less capacity used for storing motor fuel for noncommercial purposes;

(b) Tank used solely for storing heating oil for consumptive use on the premises where stored;

(c) Septic tank;

(d) Pipeline facility including gathering lines regulated under:

(i) The natural gas pipeline safety act of 1968 (49 U.S.C. app. 1671, et seq.); or

(ii) The hazardous liquid pipeline safety act of 1979 (49 U.S.C. app. 2001, et seq.); or

(iii) State laws comparable to the provisions of the law referred to in paragraph (d)(i) or (d)(ii) of this subsection as an intrastate pipeline facility;

(e) Surface impoundment, pit, pond or lagoon;

(f) Storm water or wastewater collection system;

(g) Flow-through process tank;

(h) Liquid trap or associated gathering lines directly related to oil or gas production and gathering operations;

(i) Storage tank situated in an underground area (such as a basement, cellar, mineworking, drift, shaft, or tunnel) if the storage tank is situated upon or above the surface of the floor;

(j) Tanks with a capacity of one hundred ten (110) gallons or less.

The term "underground storage tank" does not include any pipes connected to any tank which is described in paragraphs (a) through (i) of this definition.

(32) "Underground storage tank regulations" means regulations for petroleum storage tanks promulgated by the United States environmental

protection agency (EPA) pursuant to subtitle I of the solid waste disposal act, as amended by the resource conservation and recovery act, regulations promulgated by the state of Idaho as part of a state program for underground storage tank regulation under subtitle I, or other regulations affecting underground storage tank operations and management, including the international fire code adopted by the state of Idaho.

History.

I.C., § 41-4903, as added by 1990, ch. 119, § 1, p. 266; am. 1991, ch. 59, § 2, p. 113; am. 1995, ch. 132, § 12, p. 565; am. 1998, ch. 428, § 6, p. 1346; am. 2002, ch. 86, § 9, p. 195; am. 2003, ch. 96, § 2, p. 281; am. 2007, ch. 37, § 3, p. 88; am. 2009, ch. 21, § 1, p. 48; am. 2011, ch. 6, § 1, p. 14.

STATUTORY NOTES

Amendments.

The 2011 amendment, by ch. 6, inserted "ethanol, and natural gasoline" near the end of subsection (23).

Federal References.

The natural gas pipeline safety act of 1968, referred to in paragraph (31)(d)(i), has been repealed. See now 49 USCS § 60101 et seq.

The hazardous liquid pipeline safety act of 1979, referred to in paragraph (31)(d)(ii), has been repealed. See 49 USCS § 60101 et seq.

For subtitle I of the solid waste disposal act, see 42 USCS § 6991 et seq.

The resource conservation and recovery act, referred to in subsection (32), is codified as 42 USCS § 6901 et seq.

41-4910. Distribution of application fees and transfer fees.

STATUTORY NOTES

Compiler's Notes.

This section was amended by S.L. 2009, ch. 333, § 3, effective July 1, 2010. The effective date of that amendment was changed by S.L. 2010, ch. 129, § 1 to July 1, 2011. However, S.L. 2011, ch. 68, § 2 repealed S.L. 2009, ch. 333, § 3, leaving the section as last amended by S.L. 2009, ch. 332, § 5.

CHAPTER 59

IDAHO HEALTH CARRIER EXTERNAL REVIEW ACT

41-5903. Definitions. — For purposes of this chapter:

(1) "Administrative record" means all nonprivileged documents, records or other health information which was submitted, considered, generated or relied upon by the health carrier in the course of making the adverse benefit determination, including, but not limited to, documents, records or other information that constitutes the plan's policy statements or guidance concerning the denied treatment or benefit, all records provided by the covered person or the covered person's medical care provider related to the denied treatment or benefit, all records provided to an independent review

organization as part of the independent review of the denied treatment or benefit and the opinion issued by the independent review organization.

(2) "Adverse benefit determination" means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, effectiveness or has been determined to be an investigational service, and the requested service or payment for the service is therefore terminated, denied or reduced.

(3) "Ambulatory review" means utilization review of health care services performed or provided in an outpatient setting.

(4) "Authorized representative" means:

(a) A person to whom a covered person has given express written consent to represent the covered person in an external review;

(b) A person authorized by law to provide substituted consent for a covered person; or

(c) A family member of the covered person or the covered person's treating health care professional only when the covered person is unable to provide consent.

(5) "Best evidence" means evidence based on randomized clinical trials.

(a) If randomized clinical trials are not available, then cohort studies or case-control studies;

(b) If studies in paragraph (a) of this subsection (5) are not available, then case-series.

(6) "Case-control study" means a retrospective evaluation of two (2) groups of patients with different outcomes to determine which specific interventions the patients received.

(7) "Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions.

(8) "Case-series" means an evaluation of a series of patients with a particular outcome, without the use of a control group.

(9) "Certification" means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness.

(10) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by a health carrier to determine the necessity and appropriateness of health care services.

(11) "Cohort study" means a prospective evaluation of two (2) groups of patients with only one (1) group of patients receiving a specific intervention(s).

(12) "Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.

(13) "Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms and conditions of a health benefit plan.

(14) "Covered person" means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan. A covered person includes the authorized representative of the covered person.

(15) "Director" means the director of the Idaho department of insurance.

(16) "Discharge planning" means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility.

(17) "Disclose" means to release, transfer or otherwise divulge protected health information to any person other than the individual who is the subject of the protected health information.

(18) "Evidence-based standard" means the conscientious, explicit and judicious use of the current best evidence based on the overall systematic review of the research in making decisions about the care of individual patients.

(19) "Expedited external review" is the procedure available for urgent care requests for external review.

(20) "Expert" means a specialist with experience in a specific area about the scientific evidence pertaining to a particular service, intervention or therapy.

(21) "Facility" means an institution providing health care services or a health care setting, including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers and rehabilitation and other therapeutic health settings.

(22) "Final adverse benefit determination" means an adverse benefit determination, as defined in section 41-5903(2), Idaho Code, involving a covered benefit that has been upheld by a health carrier, or its designee utilization review organization, at the completion of the health carrier's internal grievance process procedures as set forth in the covered person's health benefit plan.

(23) "Health benefit plan" means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

(24) "Health care professional" means a physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law.

(25) "Health care provider" or "provider" means a health care professional or a facility.

(26) "Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

(27) "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the director, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a disability insurance company, a health maintenance organization, a nonprofit hospital

and health service corporation, or any other entity providing a plan of health insurance, health benefits or health care services.

(28) "Health information" means information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relates to:

(a) The past, present or future physical, mental or behavioral health or condition of an individual or a member of the individual's family;

(b) The provision of health care services to an individual; or

(c) Payment for the provision of health care services to an individual.

(29) "Independent review organization" means an entity that conducts independent external reviews of final adverse benefit determinations.

(30) "Investigational" means the definition provided in the covered person's health benefit plan; if the health benefit plan does not provide a definition of "investigational," it shall be defined as follows: Any treatment, procedure, facility, equipment, drug, device or commodity, regardless of its medical necessity, which is experimental, or in the early developmental stage of medical technology, for which there are no randomized clinical trials or, absent such trials, for which there are no cohort studies or case-control studies or, absent such studies, then for which there is no case-series. The determination by the health carrier will be based on objective data and information obtained by the health carrier and reviewed, by competent medical personnel, according to the following:

(a) The technology has final approval from the appropriate government regulatory bodies;

(b) Medical or scientific evidence regarding the technology is sufficiently comprehensive to permit well substantiated conclusions concerning the safety and effectiveness of the technology;

(c) The technology's overall beneficial effects on health outweigh the overall harmful effects on health; and

(d) The technology is as beneficial as any established alternative.

When used under the usual conditions of medical practice, the technology should be reasonably expected to satisfy the criteria of paragraphs (c) and (d) of this subsection (30).

(31) "Medically necessary" or "medical necessity" means the definition provided in the covered person's health benefit plan; if the covered person's health benefit plan does not define "medically necessary" or "medical necessity," these terms shall mean health care services and supplies that a physician or other health care provider, exercising prudent clinical judgment, would provide to a covered person for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

(a) In accordance with generally accepted standards of medical practice;

(b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the covered person's illness, injury or disease;

(c) Not primarily for the convenience of the covered person, physician or other health care provider; and

(d) Not more costly than an alternative service or sequence of services or supply, and at least as likely to produce equivalent therapeutic or

diagnostic results as to the diagnosis or treatment of the covered person's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible medical or scientific evidence.

(32) "Medical or scientific evidence" means evidence found in the following sources:

(a) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

(b) Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the national institutes of health's library of medicine for indexing in index medicus (MEDLINE) and elsevier science ltd. for indexing in excerpta medicus [medica] (EMBASE);

(c) Medical journals recognized by the U.S. secretary of health and human services under section 1861(t)(2) of the federal social security act;

(d) The following standard reference compendia:

(i) The American hospital formulary service — drug information;

(ii) Drug facts and comparisons;

(iii) The United States pharmacopoeia — drug information; and

(iv) The American dental association accepted dental therapeutics.

(e) Findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including:

(i) The federal agency for healthcare research and quality;

(ii) The national institutes of health;

(iii) The national cancer institute;

(iv) The national academy of sciences;

(v) The centers for medicare and medicaid services;

(vi) The federal food and drug administration; and

(vii) Any national board recognized by the national institutes of health for the purpose of evaluating the medical value of health care services; or

(f) Any other medical or scientific evidence that is comparable to the sources listed in paragraphs (a) through (e) of this subsection (32).

(33) "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing.

(34) "Post service review" means a review of medical necessity conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

(35) "Pre-service review" means utilization review conducted prior to an admission or a course of treatment.

(36) "Protected health information" means health information:

(a) That identifies an individual who is the subject of the information; or

(b) With respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

(37) "Randomized clinical trial" means a controlled, prospective study of patients who have been randomized into an experimental group and a control group at the beginning of the study with only the experimental group of patients receiving a specific intervention, which includes study of the groups for variables and anticipated outcomes over time.

(38) "Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health care service to assess the clinical necessity and appropriateness of the initial proposed health care service.

(39) "Urgent care request" means a claim relating to an admission, availability of care, continued stay or health care service for which the covered person received emergency services but has not been discharged from a facility, or any pre-service or concurrent care claim for medical care or treatment for which application of the time periods for making a regular external review determination:

(a) Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function;

(b) In the opinion of the treating health care professional with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the disputed care or treatment; or

(c) The treatment would be significantly less effective if not promptly initiated.

The opinion of the covered person's treating health care professional with knowledge of the covered person's medical condition that a request is an urgent care request should be treated with deference.

(40) "Utilization review" means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures or settings. Techniques may include ambulatory review, pre-service review, second opinion, certification, concurrent review, case management, discharge planning or post service review.

(41) "Utilization review organization" means an entity that conducts utilization review, other than a health carrier performing a review for its own health benefit plans.

History.

I.C., § 41-5903, as added by 2009, ch. 87, § 1, p. 240; am. 2011, ch. 122, § 1, p. 333.

STATUTORY NOTES

Amendments.

The 2011 amendment, by ch. 122, inserted "appropriateness, health care setting, level of care, effectiveness" near the end of subsection (2) and inserted "a claim relating to an admission, availability of care, continued stay or health care service for which the covered person received emergency services but has not been discharged from a facility, or" in the introductory paragraph in subsection (39).

Federal References.

Section 1861(t)(2) of the federal social security act, referred to in paragraph (32)(c), is

compiled as 42 USCS § 1861(t)(2).

Compiler's Notes.

For list of journals indexed for national institutes of health's national library of medicine (MEDLINE), see:

http://www.nlm.nih.gov/tsd/serials/lji.html.

For elsevier science's excerpta medica, see *http://www.elsevier.com/wps/find/journaldescription.cws_home/600580/description*.

For drug information from the American hospital formulary service, see *http://www.ahfsdruginformation.com*.

For United States pharmacopoeia, see *http://www.usp.org*.

The bracketed insertion in paragraph (32)(b) was added by the compiler to correct the name of the referenced publication.

41-5904. Applicability and scope. — (1) Except as provided in subsection (2) of this section, this chapter shall apply to all health carriers.

(2) The provisions of this chapter shall not apply to a plan, policy or certificate that provides coverage only for a specified disease, specified accident or accident-only coverage; nor shall this chapter apply to a credit, dental, disability income, hospital indemnity, long-term care insurance, vision care, limited benefit health plans or any other limited supplemental benefit; nor shall this chapter apply to a medicare advantage plan or medicare supplemental policy of insurance, as defined by the director by rule, coverage under a plan through medicare, medicaid, or the federal employees health benefits program, any coverage issued under chapter 55, title 10, of the United States Code and any coverage issued as supplemental to that coverage; nor shall this chapter apply to any coverage issued as supplemental to liability insurance, worker's compensation or similar insurance, automobile medical payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis; nor shall this chapter apply to a single employer self-funded employee benefit plan subject to and operated in compliance with the employee retirement income security act of 1974 (ERISA); provided however, the single employer self-funded ERISA employee benefit plan administrator or designee may, by timely and appropriate written notice to the director, voluntarily elect to comply with the provisions of this chapter either for a single plan beneficiary or for a specific period of time. The director may promulgate rules establishing the procedure for an employee benefit plan administrator or designee, to voluntarily comply with the provisions of this chapter and to provide for an administrative fee to be paid by the employee benefit plan administrator for each voluntary external review request submitted to the department pursuant to this chapter.

(3) The availability or use of external review pursuant to this chapter shall not alter the standard of review used by a court of competent jurisdiction when adjudicating the health carrier's final adverse benefit determination.

History.

I.C., § 41-5904, as added by 2009, ch. 87, § 1, p. 240; am. 2011, ch. 122, § 2, p. 333; am. 2011, ch. 258, § 1, p. 703.

STATUTORY NOTES

Amendments.

This section was amended by two 2011 acts which appear to be compatible and have been compiled together.

The 2011 amendment, by ch. 122, deleted "final adverse benefit determinations which involve an issue of medical necessity or investigational service or supply" from the end of subsection (1).

The 2011 amendment, by ch. 258, deleted "final adverse benefit determinations which involve an issue of medical necessity or investigational service or supply" from the end of subection (1); and, in subsection (2), added the proviso at the end of the first sentence and added the last sentence.

Federal References.

Chapter 55 of title 10 of the United States Code, referred to in subsection (2), is codified as 10 USCS § 1071 et seq.

The employee retirement income security act of 1974, referred to in subsection (2), is codified as 29 USCS § 1001 et seq.

41-5905. Notice of right to external review. — (1) When a final adverse benefit determination is made, the health carrier shall notify the covered person in writing of the covered person's right to request an external review to be conducted pursuant to section 41-5908, 41-5909 or 41-5910, Idaho Code, and include the appropriate statements and information set forth in subsection (2) of this section at the same time the health carrier sends written notice of the final adverse benefit determination.

(2) The director may prescribe by rule the form and content of the notice required under this section, which shall include:

(a) The following, or substantially equivalent, language:

> "We have denied your request for the provision of or payment for a health care service or course of treatment. You may have the right to have our decision reviewed by health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of your health care service or supply, or your health care service or supply was denied based upon a determination that it was investigational. You may request an external review by submitting a written request to the department of insurance."

The notice shall include contact information for the department of insurance, including the website, address and telephone number.

(b) If the adverse benefit determination is for a pre-service or concurrent service, the health carrier shall notify the covered person of the right to an expedited external review if the request is an urgent care request. The notification shall include the definition of urgent care request.

(c) The health carrier shall include a copy of the description of both the standard and expedited external review procedures the health carrier is required to provide pursuant to section 41-5916, Idaho Code, highlighting the provisions in the external review procedures that give the covered person the opportunity to submit additional information, and include any forms used to process an external review.

(d) The health carrier shall include an authorization form, or other document approved by the director, that complies with the requirements of 45 CFR section 164.508, by which the covered person, for purposes of

conducting an external review pursuant to this chapter, authorizes the health carrier and the covered person's treating health care providers to disclose protected health information, including medical records, concerning the covered person that are pertinent to the external review. Until the director receives this form from the covered person, duly executed, the external review process is stayed and the health carrier has no obligations under this chapter.

History.
I.C., § 41-5905, as added by 2009, ch. 87, § 1, p. 240; am. 2011, ch. 122, § 3, p. 333.

STATUTORY NOTES

Amendments.
The 2011 amendment, by ch. 122, substituted "When a final adverse benefit determination is made" for "If at the conclusion of the health carrier's internal grievance process the decision is adverse to the covered person, based upon a determination that the service or supply to be provided or which was provided did not meet medical necessity criteria or is investigational" at the beginning of subsection (1); in paragraph (2)(a), inserted "appropriateness, health care setting, level of care or effectiveness"; and, in subsection (2)(b), deleted "and was denied based upon a failure to meet medical necessity criteria or because the service was determined to be investigational" following "concurrent service."

41-5906. Request for external review. — A covered person may make a request for an external review of a final adverse benefit determination. Except for a request for an expedited external review as set forth in section 41-5909, Idaho Code, all requests for external review shall be made in writing to the director. The director may prescribe by rule the form and content of external review requests required to be submitted under this section.

History.
I.C., § 41-5906, as added by 2009, ch. 87, § 1, p. 240; am. 2011, ch. 122, § 4, p. 333.

STATUTORY NOTES

Amendments.
The 2011 amendment, by ch. 122, substituted "for" for "to" in the section heading and deleted the former last sentence, which read: "The director shall prescribe by rule the amount of the administrative filing fee, if any, to be paid by the covered person when the external review request is submitted."

41-5907. Exhaustion of internal grievance process. — (1) Except as provided in subsection (2) of this section, a request for an external review pursuant to section 41-5908, 41-5909 or 41-5910, Idaho Code, shall not be made until the covered person has exhausted the health carrier's internal grievance process. A covered person shall be considered to have exhausted the health carrier's internal grievance process for purposes of this section, if the covered person:

(a) Has filed and completed a grievance, involving an adverse benefit determination, according to the terms and conditions of the covered person's health benefit plan; or

(b) Except to the extent the covered person requested or agreed to a delay, has not received a written decision on the grievance from the health

carrier within thirty-five (35) days following the date the covered person filed the grievance with the health carrier, or the covered person filed a grievance on an urgent care request on a pre-service or concurrent care adverse benefit determination and has not received a determination from the health carrier within three (3) business days after filing.

(2) A request for an external review of an adverse benefit determination may be made before the covered person has exhausted the health carrier's internal grievance procedures as set forth in the health carrier's grievance appeal process whenever:

(a) The health carrier agrees to waive the exhaustion requirement;

(b) The health carrier has failed to strictly follow its duties in affording a timely, full and fair opportunity for the covered person to take advantage of the internal grievance procedures; or

(c) The urgent care request involves a medical condition for which the time frame for completion of the carrier's internal grievance process pursuant to this section would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, and the covered person has applied for expedited external review at the same time as applying for an expedited internal review.

History.

I.C., § 41-5907, as added by 2009, ch. 87, § 1, p. 240; am. 2011, ch. 122, § 5, p. 333.

STATUTORY NOTES

Amendments.

The 2011 amendment, by ch. 122, added present paragraphs (2)(b) and (2)(c), and made related redesignations; and deleted former subsection (2), which read: "If the requirement to exhaust the health carrier's internal grievance procedures is waived under subsection (1)(b) of this section, the covered person may file a request in writing for a standard external review, or where appropriate, an expedited external review."

41-5908. Standard external review. — (1) Within four (4) months after the date of issuance of a notice of a final adverse benefit determination pursuant to section 41-5905, Idaho Code, a covered person may file a request for an external review with the director. The request shall be made on such form as may be designated by the director.

(2) Within seven (7) days after the date of receipt of a request for external review pursuant to subsection (1) of this section, the director shall send a copy of the request to the health carrier.

(3) Within fourteen (14) days following the date of receipt of the copy of the external review request from the director pursuant to subsection (2) of this section, the health carrier shall complete a preliminary review of the request to determine whether:

(a) The individual is or was a covered person in the health benefit plan at the time the health care service was requested or, in the case of a post service review, was a covered person in the health benefit plan at the time the health care service was provided;

(b) The health care service that is the subject of the final adverse benefit determination is a covered service under the covered person's health

benefit plan, but for a determination by the health carrier that the health care service is not covered because it does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, effectiveness or the service or supply is investigational;

(c) The covered person has exhausted the health carrier's internal grievance process as set forth in the covered person's health benefit plan, unless the covered person is not required to exhaust the health carrier's internal grievance process pursuant to section 41-5907, Idaho Code; and

(d) The covered person has provided all the information and forms required to process an external review, including the release form provided under section 41-5905(2)(d), Idaho Code.

(4) Within five (5) business days after completion of the preliminary review, the health carrier shall notify the director and covered person in writing whether the request is complete and whether the request is eligible for external review.

(5) If the request is not complete, the health carrier shall inform the covered person and the director in writing and include in the notice what information or materials are needed to make the request complete.

(6) If the request is not eligible for external review, the health carrier shall inform the covered person and the director in writing and include in the notice the reasons for its ineligibility.

(7) The director may prescribe by rule the form for the health carrier's notice of initial determination under this section and any supporting information to be included in the notice. The notice of initial determination shall include a statement informing the covered person that a health carrier's initial determination that the external review request is ineligible for review, may be appealed to the director.

(8) The director may determine that a request is eligible for external review notwithstanding a health carrier's initial determination that the request is ineligible and require that it be referred for external review. The director's decision shall be made in accordance with the applicable procedural requirements of this chapter and the terms and conditions of the covered person's health benefit plan.

(9) Whenever the director receives a notice that a request is eligible for external review following the preliminary review conducted pursuant to subsection (3) of this section, within seven (7) days after the date of receipt of the notice, the director shall:

(a) Assign an independent review organization from the list of approved independent review organizations compiled and maintained by the director pursuant to section 41-5911, Idaho Code, to conduct the external review and notify the health carrier of the name of the assigned independent review organization; and

(b) Notify, in writing, the covered person of the request's eligibility and acceptance for external review.

(c) The director shall include in the notice provided to the covered person a statement that the covered person may submit, in writing, to the assigned independent review organization within seven (7) days following the date of receipt of the notice provided pursuant to subsection (9)(b) of this section, additional information that the independent review organization shall consider when conducting the external review.

(10) In reaching a decision, the assigned independent review organization is not bound by the exercise of discretion or any decisions or conclusions reached during the health carrier's utilization review process or the health carrier's internal grievance process.

(11) Within fourteen (14) days after the date of receipt of the notice provided pursuant to subsection (9)(a) of this section, the health carrier or its designee utilization review organization shall provide to the assigned independent review organization the documents and any information considered in making the adverse benefit determination or final adverse benefit determination.

(12) Except as provided in subsection (13) of this section, failure by the health carrier or its utilization review organization to provide the documents and information within the time specified in subsection (11) of this section, shall not delay the conduct of the external review.

(13) If the health carrier or its utilization review organization fails to provide the documents and information within the time specified in subsection (11) of this section, the assigned independent review organization may terminate the external review and make a decision to reverse the adverse benefit determination or final adverse benefit determination.

(14) Within one (1) business day after making the decision to terminate the external review pursuant to subsection (13) of this section, the independent review organization shall notify the covered person, the health carrier and the director.

(15) The assigned independent review organization shall review all of the information and documents received pursuant to subsection (11) of this section, and any other information submitted in writing to the independent review organization by the covered person pursuant to subsection (9)(c) of this section; provided however, that if the covered person does submit new information in writing to the independent review organization pursuant to subsection (9)(c) of this section, then the health carrier is entitled to seven (7) days following its receipt thereof to submit additional responsive information to the internal review organization.

(16) Upon receipt of any information submitted by the covered person pursuant to subsection (9)(c) of this section, the assigned independent review organization shall within one (1) business day forward the information to the health carrier.

(17) Upon receipt of the information, if any, required to be forwarded pursuant to subsection (16) of this section, the health carrier may reconsider its adverse determination or final adverse benefit determination that is the subject of the external review. Reconsideration by the health carrier of its adverse determination or final adverse determination shall not delay or terminate the external review. The assigned independent review organization shall review all of the information and documents received pursuant to subsection (15) of this section.

(18) The external review may be terminated if the health carrier decides to reverse its final adverse benefit determination and provide coverage or payment for the health care service that is the subject of the final adverse benefit determination. Within two (2) business days after making the

decision to reverse its final adverse benefit determination, the health carrier shall notify the covered person, the assigned independent review organization and the director in writing of its decision.

(19) In addition to the documents and information provided pursuant to subsection (11) of this section, the assigned independent review organization, to the extent the information or documents are available, shall consider the following in reaching a decision:

(a) The covered person's medical records;

(b) The attending health care professional's recommendation;

(c) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person or the covered person's treating provider;

(d) The terms and conditions of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is controlled by the terms and conditions of coverage under the covered person's health benefit plan with the health carrier to the extent the health plan's terms and conditions are not in conflict with this chapter;

(e) The most appropriate practice guidelines, which shall include the applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations, health carrier's internal guidelines and medical policies;

(f) Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization;

(g) Medical or scientific evidence, as defined in section 41-5903(32), Idaho Code;

(h) The opinion of the independent review organization's clinical reviewer or reviewers after considering paragraphs (a) through (g) of this subsection (19) to the extent the information or documents are available.

(20) Within forty-two (42) days after the date of receipt of the request for an external review, the assigned independent review organization shall provide written notice of its decision to uphold or reverse the final adverse benefit determination to the covered person, the health carrier and the director. The independent review organization shall include in the notice:

(a) A general description of the reason for the request for external review;

(b) The date the independent review organization received the assignment from the director to conduct the external review;

(c) The date the external review was conducted;

(d) The date of its decision;

(e) The principal reason or reasons for its decision, including an explanation of the scientific or clinical judgment applied to reach its decision;

(f) References to the evidence or documentation, including the evidence-based standards, considered in reaching its decision; and

(g) References to the terms and conditions of the health benefit plan at issue, including an explanation of how its decision is consistent with them.

(21) The assignment by the director of an approved independent review organization to conduct an external review in accordance with this section

shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the final adverse benefit determination and other circumstances, including conflict of interest concerns pursuant to section 41-5912, Idaho Code.

(22) Upon receipt of a notice of a decision pursuant to subsection (20) of this section reversing the adverse benefit determination or final adverse benefit determination, the health carrier shall approve as soon as reasonably practicable but not later than one (1) business day after receipt of the notice the coverage that was the subject of the adverse benefit determination or final adverse benefit determination.

History.
I.C., § 41-5908, as added by 2009, ch. 87, § 1, p. 240; am. 2011, ch. 122, § 6, p. 333.

STATUTORY NOTES

Amendments.
The 2011 amendment, by ch. 122, inserted "appropriateness, health care setting, level of care, effectiveness" in subsection (3)(b); substituted the last occurrence of "independent" for "internal" in subsection (15); and added subsection (22).

41-5909. Expedited external review. — (1) A covered person may make a request for an expedited external review of a pre-service or concurrent service adverse benefit determination where the requested service meets the definition of an urgent care request and the covered person has exhausted the health carrier's internal grievance process or is entitled to request external review before exhausting the health carrier's internal grievance process as provided in section 41-5907, Idaho Code.

(2) Upon receipt of a request for an expedited external review, the director shall send a copy of the request to the health carrier.

(3) Upon receipt of the request pursuant to subsection (2) of this section, the health carrier shall determine, as soon as possible but not later than the second full business day thereafter, whether the carrier agrees that the request meets the reviewability requirements set forth in section 41-5908(3), Idaho Code. The health carrier shall notify the director and the covered person of its eligibility determination as soon as reasonably practicable but not later than one (1) business day after making the determination.

(a) The director may prescribe by rule the form for the health carrier's notice of initial determination under this subsection and any supporting information to be included in the notice.

(b) The notice of initial determination shall include a statement informing the covered person that a health carrier's initial determination that an external review request is ineligible for review, may be appealed to the director.

(4) The director may determine that a request is eligible for external review pursuant to section 41-5908(3), Idaho Code, notwithstanding a health carrier's initial determination that the request is ineligible, and

require that it be referred for external review. In making a determination under this subsection (4), the director's decision shall be made in accordance with the applicable procedural requirements of this chapter and the terms and conditions of the covered person's health benefit plan.

(5) Upon receipt of the notice that the request meets the reviewability requirements, the director shall assign an independent review organization to conduct the expedited external review from the list of approved independent review organizations compiled and maintained by the director pursuant to section 41-5911, Idaho Code. The director shall notify the health carrier and the covered person of the name of the assigned independent review organization.

(6) In reaching a decision in accordance with subsection (9) of this section, the assigned independent review organization is not bound by the exercise of discretion or any decisions or conclusions reached during the health carrier's internal grievance process.

(7) Upon receipt of the notice from the director of the name of the independent review organization assigned to conduct the expedited external review pursuant to subsection (5) of this section, the health carrier or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse benefit determination and the final adverse benefit determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.

(8) In addition to the documents and information provided or transmitted pursuant to subsection (7) of this section, the assigned independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

(a) The covered person's pertinent medical records;

(b) The attending health care professional's recommendation;

(c) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person or the covered person's treating provider;

(d) The terms and conditions of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is controlled by the terms and conditions of coverage under the covered person's health benefit plan with the health carrier to the extent the health plan's terms and conditions are not in conflict with this chapter;

(e) The most appropriate practice guidelines, which shall include evidence-based standards, and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations, the health carrier's internal guidelines and medical policies;

(f) Any applicable clinical review criteria developed and used by the health carrier or its designated utilization review organization in making the adverse benefit determination;

(g) Medical or scientific evidence, as defined in section 41-5903(32), Idaho Code;

(h) The opinion of the independent review organization's clinical reviewer or reviewers after considering paragraphs (a) through (g) of this subsection (8) to the extent the information and documents are available.

(9) As expeditiously as the covered person's medical condition or circumstances require, but in no event more than seventy-two (72) hours after the date of receipt of the request for an expedited external review that meets the reviewability requirements set forth in section 41-5908(3), Idaho Code, the assigned independent review organization shall:

(a) Make a decision to uphold or reverse the final adverse benefit determination; and

(b) Notify the covered person, the health carrier and the director of the decision.

(10) If the notice provided pursuant to subsection (9)(b) of this section was not in writing, within forty-eight (48) hours after the date of providing that notice, the assigned independent review organization shall:

(a) Provide written confirmation of the decision to the covered person, the health carrier and the director, which shall include an explanation of the scientific or clinical judgment for the determination; and

(b) Include the information set forth in section 41-5908(20), Idaho Code.

(11) Upon receipt of the notice of a decision pursuant to subsection (10) of this section reversing the final adverse benefit determination, the health carrier shall notify the director and the covered person of its intent to pay the covered benefit as soon as reasonably practicable but not later than one (1) business day after receiving the notice of decision.

(12) An expedited external review shall not be provided for post service final adverse benefit determinations.

(13) The assignment by the director of an approved independent review organization to conduct an external review in accordance with this section shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the final adverse benefit determination and other circumstances, including conflict of interest concerns pursuant to section 41-5912, Idaho Code.

History.

I.C., § 41-5909, as added by 2009, ch. 87, § 1, p. 240; am. 2011, ch. 122, § 7, p. 333.

STATUTORY NOTES

Amendments.

The 2011 amendment, by ch. 122, in subsection (1), deleted "After having exhausted the health carrier's internal grievance process as provided in section 41-5907, Idaho Code" from the beginning, deleted "based on medical necessity or investigational" following "determination," and added "and the covered person has exhausted the health carrier's internal grievance process or is entitled to request external review before exhausting the health carrier's internal grievance process as provided in section 41-5907, Idaho Code"; in paragraph (10)(a), deleted "addressing the medical necessity criteria as defined in this chapter or, where the appeal is based upon a denial of a service as investigational, addressing the criteria for determination of investigational status as defined in this chapter" from the end; and, in subsection (11), substituted "its intent to pay the covered benefit" for "its eligibility determination" and substituted "after receiving the notice of decision" for "after making the determination."

41-5915. Funding of external review. — The health carrier against which a request for a standard external review or an expedited external review is filed shall pay the reasonable cost of the independent review organization for conducting the external review.

History.
I.C., § 41-5915, as added by 2009, ch. 87, § 1, p. 240; am. 2011, ch. 122, § 8, p. 333.

STATUTORY NOTES

Amendments.
The 2011 amendment, by ch. 122, deleted the former last sentence, which read: "The director may provide by rule for an administrative fee to offset the department's costs associated with external review to be paid by the covered person at the time he makes a request for external review."

41-5916. Disclosure requirements. — (1) Each health carrier shall include a summary description of the external review procedures in or attached to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage it provides to covered persons. The disclosure shall be in a format prescribed by the director.

(2) The description required under subsection (1) of this section shall include:

(a) A statement that informs the covered person of the right of the covered person to file a request for an external review of a final adverse benefit determination with the director;

(b) An explanation that external review and, in certain circumstances, expedited external review are available when the final adverse benefit determination involves an issue of medical necessity, appropriateness, health care setting, level of care, effectiveness or investigational service or supply;

(c) The website, telephone number and address of the director; and

(d) A statement informing the covered person that, when filing a request for an external review, the covered person will be required to authorize the release of any medical records of the covered person that may be required to be reviewed for the purpose of reaching a decision on the external review including any judicial review of the external review decision pursuant to ERISA, if applicable.

(e) If the health plan is not subject to ERISA, a statement informing the covered person that the plan is not subject to ERISA and that if the covered person elects to request external review, the external review decision of the independent review organization shall be final and binding on both the covered person and the health carrier, as provided in section 41-5910, Idaho Code. If the health plan is subject to ERISA, the statement shall inform the covered person that the plan is subject to ERISA and that if the covered person elects to request external review, the external review decision of the independent review organization shall be final and binding on the health carrier but not the covered person, as provided in section 41-5910, Idaho Code, and that the covered person may have the right to judicial review under ERISA in a court of competent jurisdiction.

History.
I.C., § 41-5916, as added by 2009, ch. 87, § 1, p. 240; am. 2011, ch. 122, § 9, p. 333.

STATUTORY NOTES

Amendments.
The 2011 amendment, by ch. 122, inserted "appropriateness, health care setting, level of care, effectiveness" in paragraph (2)(b).

Federal References.
ERISA, the employee retirement income security act of 1974, referred to in this section, is codified as 29 USCS § 1001 et seq.

CHAPTER 60

IMMUNIZATION ASSESSMENTS

SECTION.

41-6005. Power and liability of the board. [Null and void, effective July 1, 2013.] — (1) The board shall have the power to:

(a) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this chapter, including contracts for administrative services;

(b) Determine the method of assessment and assess carriers in accordance with the provisions of section 41-6006, Idaho Code;

(c) Require carriers to provide to the board such statements and reports the board deems necessary to fulfill its duties under this chapter;

(d) Establish policies and procedures as may be necessary or convenient for the implementation of this chapter and the operation of the assessments authorized by this chapter; and

(e) Consult with the Idaho department of health and welfare and other experts as the board may deem appropriate as necessary or proper to carry out the provisions and purposes of this chapter.

(2) Neither the board nor its members shall be liable for any obligations of the vaccine assessments. No member or employee of the board shall be liable, and no cause of action of any nature may arise against them, for any act or omission related to the performance of their powers and duties under this chapter, unless such act or omission constitutes willful or wanton misconduct. Participation by a carrier in the assessments authorized by this chapter or on the board under the provisions of this chapter shall not be grounds for any legal action, criminal or civil liability, or penalty against the fund or any of its carriers or board members, either jointly or separately.

History.
I.C., § 41-6005, as added by 2010, ch. 32, § 1, p. 60; am. 2011, ch. 121, § 1, p. 331.

STATUTORY NOTES

Amendments.

The 2011 amendment, by ch. 121, added "including contracts for administrative services" in paragraph (1)(a) and added paragraph (1)(e).

Compiler's Notes.

Section 4 of S.L. 2010, ch. 32 provided: "The provisions of this Chapter 60, Title 41 shall be null, void and of no force and effect on or after July 1, 2013."

41-6006. Assessments. [Null and void, effective July 1, 2013.] — (1) The department of health and welfare shall report to the board on or before January 1 the total number of program eligible children in the Idaho immunization reminder information system registry who received vaccines, the doses and the total nonvaccine-for-children funds expended for vaccines purchased and administered through the Idaho immunization program for the previous state fiscal year and any other information appropriate or necessary to enable the board to properly determine assessments under the provisions of this chapter.

(2) The assessments to fund vaccine purchases for program eligible children shall be made annually by the board. Each carrier's proportion of the assessment and the dates upon which the carrier must pay the assessment into the fund shall be determined by the board based on annual statements and other reports deemed necessary by the board. In making the assessment determination, the board shall consider such factors as any surplus funds remaining from a prior assessment, the number and cost of vaccine doses expected to be administered in the pertinent time period and the number of program eligible children in the pertinent time period, as well as any necessary costs and expenses to administer the fund and discharge the duties of the board. The annual assessment shall be calculated to provide funding that, at a minimum, is expected to be sufficient to cover the administrative costs of the board and fund the purchase of vaccines for program eligible children that have in effect a recommendation from the advisory committee on immunization practices of the centers for disease control and prevention on the date the board makes its assessment determination.

(3) For late or nonpayment of assessments by a carrier, the director shall impose interest at the rate provided by section 28-22-104(1), Idaho Code, and may impose such other penalties as provided in title 41, Idaho Code.

(4) Except as otherwise provided in this subsection, a carrier shall pay an assessment made by the board within sixty (60) days of the notice of assessment being sent to the carrier. For good cause, a carrier may seek from the director a deferment from all or part of an assessment imposed by the board. The director may defer all or part of the assessment if the director determines that the payment of the assessment would place the carrier in a financially impaired condition, as provided in title 41, Idaho Code. If all or part of an assessment against a carrier is deferred, the amount deferred shall be assessed against the other carriers in a manner consistent with the basis for assessment set forth in this section. The carrier receiving the deferment shall remain liable to the fund for the amount deferred and shall be prohibited from insuring any new individuals in the state of Idaho until such time as it pays the assessments.

(5) The moneys raised by the assessment authorized in this section shall be used solely for the purposes expressly authorized by this chapter.

History.
I.C., § 41-6006, as added by 2010, ch. 32, § 1, p. 60; am. 2011, ch. 121, § 2, p. 331.

STATUTORY NOTES

Amendments.
The 2011 amendment, by ch. 121, in subsection (1), deleted "on or before March 1, 2010, and" following "shall report to the board" and deleted "thereafter" following "January 1" and added "and any other information appropriate or necessary to enable the board to properly determine assessments under the provisions of this chapter"; in subsection (2), added the first sentence, in the third sentence, inserted "any surplus funds remaining from a prior assessment," "and cost," and "expected to be" and added the last sentence; deleted former subsection (5), which read: "The initial assessments as determined by the board shall be paid into the fund on or before April 1, 2010"; and redesignated former subsection (6) as present subsection (5).

Compiler's Notes.
Section 4 of S.L. 2010, ch. 32 provided: "The provisions of this Chapter 60, Title 41 shall be null, void and of no force and effect on or after July 1, 2013."

41-6007. Idaho immunization dedicated vaccine fund. [Null and void, effective July 1, 2013.] — There is hereby created in the state treasury the Idaho immunization dedicated vaccine fund. Moneys in the fund shall be appropriated solely for purposes established by this chapter. All funds in excess to the cost required to perform the administrative functions required under this chapter shall be paid to the Idaho department of health and welfare for the sole purposes of purchasing vaccine for use in the Idaho immunization program. Any moneys in excess of the amount needed to fund the Idaho immunization program for a given period shall be retained by the Idaho department of health and welfare to be used to fund the program in subsequent periods, including a subsequent period after the date this chapter is no longer in effect. The fund and any assessments imposed or collected pursuant to the operation of the fund shall at all times be free from taxation of every kind.

History.
I.C., § 41-6007, as added by 2010, ch. 32, § 1, p. 60; am. 2011, ch. 121, § 3, p. 331.

STATUTORY NOTES

Amendments.
The 2011 amendment, by ch. 121, in the second sentence, substituted "required to perform the administrative functions required under this chapter" for "required to develop and amend a plan of operation as permitted in section 41-6004, Idaho Code" and added the third sentence.

Compiler's Notes.
Section 4 of S.L. 2010, ch. 32 provided: "The provisions of this Chapter 60, Title 41 shall be null, void and of no force and effect on or after July 1, 2013."